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ORIGINAL DEPARTMENT.

CLINICAL LECTURE.

SURGICAL CLINIC.

BY A. G. GERSTER, M.D.,

PROFESSOR OF SURGERY IN THE NEW YORK POLYCLINIC.

Varicocele.

Gentlemen:—The first case to which I would call your attention is one of varicocele, to be operated upon at the German Hospital this afternoon. The patient is about twenty years of age. The varicocele is bilateral; but, as usual, it is more marked on the left side than on the right. There are good anatomical reasons for that, which I need not dwell upon now. I will limit my remarks to some of the methods employed in the treatment of this affection. Formerly, as you must know, varicocele was considered an *opprobrium chirurgicorum*. While some surgeons were devising new methods of cure, others were condemning all methods because they involved great risk. By great risk I mean the risk of pyogenic infection, or a suppurative inflammation. In varicocele there is a bunch of veins, in a distended condition, arranged about the cord in the scrotum, belonging to the pampiniform plexus. In these veins, as in all veins affected with suppurative inflammation, thrombi form; and these thrombi, being invaded by pyogenic organization, decompose. Portions may become detached, and may be carried into the general circulation, perhaps become lodged in the lungs and form pulmonary abscesses. The older surgeons warned against all operations for

varicocele, because pyæmia was so very frequently observed after such operations. Nevertheless, it must be said that some of the surgeons had very good results, even in those older times. They could not understand this difference in results: why it was that all the patients of one surgeon had suppuration and became dangerously ill, many even losing their lives, from an attempt to cure an affection which is not dangerous to life at all; and why the patients, or very many of them, operated upon by other surgeons recovered with little trouble. The reason for this difference in results can now be readily accounted for: it is that the successful surgeons were cleanly, the unsuccessful ones were filthy, in their manipulations. In those days they said, "This man is an unlucky surgeon; that one a lucky surgeon." For they both operated skillfully, and apparently on the same principles in the same manner. Yet the results were very different.

Now the operation for varicocele is known to be proper, to be justifiable. If the case is a mild one, a mild operation is appropriate; and a good procedure is that proposed by our fellow-townsmen, Dr. Keyes: namely, subcutaneous ligation of a portion of the veins returning from the testes. It is a very simple operation, which can readily be carried out in your office with local anæsthesia. This procedure may be adopted on the right side in this case; while on the left side, where the affection is a good deal more extensive, it would not be sufficient. There we will have to do more: we will have to lay open the plexus of veins, and dissect out those which are not essential to nutrition. This is done after first putting on a

double ligature, the veins between the ligatures being excised. Just enough are left to carry away the venous blood from the testicle and epididymis. If we did not leave at least one or two of those veins, the result would be that the artery supplying the testicle with blood would continue to carry blood to that organ, but there would be no chance for it to return. There would be engorgement, cedema, passive hyperæmia, and, as a result of that, we might look forward to two possibilities. The one being that through some small branch veins incomplete collateral circulation would be established. In that case the venous engorgement would not be so great. Most of the blood would remain; but a portion of it would be eliminated, returned to the general circulation by this rather insufficient collateral circulation.

As a result of this want of balance between the arterial supply and the venous reflux, we would see, as we always see under similar circumstances: first, hyperæmia; then hypertrophy,—consisting principally of an increase of the connective-tissue elements. Afterwards these elements would become atrophied, contracted, and would smother that which constitutes the essential characteristic of the testicle: the glandular structure. Therefore, as a consequence of a badly-performed operation, there would be gradual atrophy and shrinking away of the testicle, and you would have robbed the man of one-half of his generative power. If the veins leading from the testicle should all be excised, and the venous return be entirely destroyed, there would be rapid necrosis of the organ. That, of course, would be a great deal more serious than the result just spoken of as following almost complete interruption of the venous return; the patient would attribute the result directly to the operation. But when the testicle gradually atrophies and shrinks away, the patient notices it less; very frequently he does not know that that testicle is not able to perform its function, for he has another one which answers the purpose of the two. But when necrosis takes place, the patient looks upon it as a very serious matter. Still, atrophy of both testicles is a very serious matter. One, who had been operated upon by a renowned French surgeon with that result, felt so grieved by it that he waylaid the surgeon and killed him. Let that example serve you as a warning. Last year necrosis of the testicle followed one of my operations for varicocele. The patient was a baker, and bakers, I may here state,

are very prone to varicocele. It is perhaps due to their standing and unhygienic occupation. They sleep part of the day, and work all night in a heavy atmosphere. They may drink hard, and live as men should not live. As a consequence, we find them anæmic, ill-nourished, and when they acquire a disease, it remains with them longer than it would with a well nourished man who leads a hygienic life.

My patient had varicocele in a very marked degree, and I proposed treatment by excision. I found it very difficult in that case to decide what veins should be removed and what ones should remain. I thought I had left a sufficient number (three or four small trunks) to carry away the venous blood from the testicle. The antiseptic measures observed must have been defective; for, although we had no suppuration proper, yet there was a good deal of infiltration and inflammation of the parts, with slight elevation of temperature—conditions which we usually do not see after antiseptic operations. These lapses from perfect antiseptics are liable to occur to everybody; and I therefore warn you, young men, those who are commencing to work antiseptically, not to boast with your antiseptics. Be conscientious in carrying them out, but never be too sure that you have succeeded; never promise your patient that the wound will surely heal without trouble; especially, be not too harsh in your judgment of the work of other surgeons, for if you are, your next case, in which you think you have followed antiseptic rules in the most exact way, may be followed by suppuration and prove conclusively that your antiseptics had been imperfect. We should not carry our heads too high. Let us do our duty, but never think we are infallible. In the case of which I am speaking, thrombosis of some of the veins occurred, which interfered with the reflux of the blood from the testicle and epididymis, and the testicle necrosed. The first change of dressing was made, I believe, on the seventh day after the operation; we were led to suspect that something was wrong from an elevation of the temperature, and what we found was a yellowish, necrosed testicle. The man was afterward discharged cured, without that testicle.

I may mention as a historical fact that the operation for varicocele is one of the oldest. The Latin, Greek and Indian writers mention the treatment of the affection. The Eastern writers mention it, but they operated in a very radical way. They simply cut off the man's scrotum with the testicle, and that disposed of the whole business.

This afternoon, I shall demonstrate to you two methods. The first, Keyes' method, as I have said, is a very easy one, and can be done, allowing the patient to visit you at your office. The second method is graver, and is performed, in the manner which I have just described, by cutting down upon the enlarged veins where they return from the epididymis, tying them with a double ligature, and dissecting out all but a few branches, which are left to carry away the venous blood. The result of this operation is good. This method is supplemented by partial amputation of the scrotum when that structure has become very redundant and relaxed. As you know, the scrotum is very redundant in its normal state, and a large portion of it may be removed without danger to the patient from shrinkage of the tissues. Some authors think that removal of part of the scrotal integument is in itself sufficient to effect a cure of the varicocele, and that method has been recommended for the cure of these patients. But the results of the operation have not been favorable. When I was a student, I saw cases treated in this manner, but as soon as the initial density of the cicatrix, the tenacity of the newly-formed cicatricial tissue was gone, it became stretched, and the varicocele became worse than before the operation.

Commencing Hip-Joint Disease.

Here is a little girl brought to us by her father for a diagnosis. Before entering upon the history of the case you should always glance the patient over, and make an estimate of her general condition. You observe that she has rather a pale, anæmic integument, covering rather a good supply of flabby fat. The mucous membranes are pale; there is a slight amount of blepharitis; the nostrils are a little reddened. Examining the surface on the legs, we see a number of little eruptions, indicating the presence of eczema; in short, we have to deal with a child which is anæmic, which has the so-called lymphatic habit. Her father tells me she has never had sore throat; nevertheless the cervical, sub-maxillary, and posterior cervical glands are intumescent. Her general condition is a characteristic one.

Her father tells us that five days ago she sustained a fall on the floor, since which time she limps. Watch the child walk. Her gait is limping, which circumstance may indicate incipient disease. Those doctors who handle horses a good deal, acquire a skill enabling them at once to tell whether or not a horse is lame. This skill may aid them to

tell on which leg a patient limps. The principle is the same. A lame person rests as short a time as possible upon a diseased limb when walking, and throws his weight more heavily upon the sound limb. By observing this child's walk carefully, you will see that it limps on the right limb. You may be able to determine this point only after seeing the patient walk three or four times, dressed and undressed. You should hesitate to say in a case, with apparently very slight symptoms, that the child has not hip-joint disease. That is a point which often baffles the diagnostic skill of young practitioners. They pronounce quickly that the disease is absent, when older practitioners would be more wary and reserved. It is human nature to tell people what they want to hear. A case is brought to him in which the diagnosis of hip-joint disease has been made; the parents are anxious, but they do not believe that the diagnosis is correct. It is only poor people, they think, who have hip-joint disease. Of course nothing will sound better to them than to hear from the young doctor, who has graduated with honors, and has travelled through Germany and other foreign countries, who knows how to handle the microscope, etc., "all nonsense; this child has not hip disease." But the truth is bound to come out. After a time the hip-joint disease makes itself only too manifest, and then the young physician rues his mistake.

We have seen that this child in walking has to limp. Now let us determine where the cause of that limping is located; whether in the tarsus, in the ankle, the knee, or the hip joint. The father of the patient tells us that she has been lame only five days, at which time she sustained a fall. But not infrequently we are able to bring out the fact that the patient had limped a longer time than that given by the parents, and that she had had a previous fall. Sayre says that hip-joint disease is always caused by traumatism. There is no doubt that traumatism has a good deal to do with the development of not only hip-joint disease, but of any joint disease belonging to the group of tuberculous complaints. But, gentlemen, very frequently the traumatism is a consequence of the tubercular joint disease. Not always. Very frequently when there is a tubercular condition in a joint disabling it to a certain extent, the child falls, this resulting in apparent injury to that joint. Let me call your attention to the fact that the bronchial glands are most commonly the primary seat of tuberculosis in children. Tuberculosis of the bronchial glands most frequently appears after an

attack of measles. Old practitioners will tell you that the foundation for a so-called lymphatic habit is ordinarily laid down after an attack of measles. The little patients languish, remain anæmic and puny, and are very prone to chronic joint trouble. Now, if such a child in such a condition falls and strikes upon the elbow, an extravasation will take place in the injured bone adjoining the elbow. That extravasation furnishes an excellent bed for the bacillus tuberculosis; it will settle there and propagate. Then there follows the development of a cheesy focus. Yet the child may be able to play about with its companions and manifest no symptoms further than some stiffness in the morning of the affected joint. It has no fever. The complexion is pale, it is true, but that is common in city children. It takes a skillful eye to detect slight intumescence of the joint. But another traumatism takes place when there is intervening between the cheesy focus and interior of the joint only a very thin lamella of bone and cartilage. The result of the fall is that the thin lamella or bone is broken through, cheesy matter enters the joint, swelling takes place, the child's temperature rises, the doctor is called in and finds acute joint trouble. He diagnoses traumatic synovitis, recommends the usual treatment for that affection, and predicts rapid improvement. We know that the joint of a healthy person, of a healthy child especially, although contused with great force, will recover in a fortnight under proper treatment. But in the class of cases under consideration it will not recover as rapidly. Although the doctor had predicted that the child would soon recover, it will not. The swelling due to serous effusion may in part disappear, but the joint remains thickened; it does not shrink back to its normal size and contour, as it would do in simple traumatic effusion. On examining such a joint carefully you will find there is present swelling, intumescence of the capsule, and frequently not only of the capsule, but also of the subcutaneous connective tissue; in fact all the soft parts surrounding the joint are imbued with a peculiar gelatinous material. This is frequently verified on the operating table.

In inspecting cases of joint disease, it is necessary to observe the external contour, the disposition of the soft parts. It will not do to expose the joint of one limb alone. It is very necessary to compare the affected with the sound limb.

Most of the signs of hip-joint disease have not yet developed, or, rather, are absent in this case. There is absence of flexion of the

high region of the pelvis; difference in the size of the nates is also absent in this case. When there is great intumescence and a large amount of gelatinous material in the joint, the whole gluteal region on the affected side is raised. On palpation, in such a case, you will notice distinct swelling and thickening, and by making deep pressure between the great trochanter and head of the femur the patient will give evidence of pain.

First examine the ankle joint. It is better to assume that we do not know the source of the lameness, and examine all the joints in succession, beginning with the ankle. Having noticed the contour of the joint, we then flex, extend, rotate inward, then rotate outward. Do the same with the knee. Both ankle and knee are normal. Having proceeded upward to the hip-joint, we there make a strong flexion upon the pelvis, and then rotation outward. Having gone through with the examination on one side, and found nothing abnormal, we proceed to examine the other.

Occasionally, I have found in hip-joint disease all movements of the joint free to a certain extent, excepting perhaps one. Rotation in one direction may be impeded, or all the movements be free excepting abduction. In this case there is little impediment to motion until we come to abduction during flexion; there the pelvis follows the limb most distinctly, a great deal more so than on the other side, where in fact it does not follow the limb at all. In rotation also the pelvis follows to some extent. Now we will try the most important test, that is, flexion, and at the same time abduction or rotation outward. The pelvis follows. We can move the entire body in attempting to flex and abduct the left thigh. The question of whether the thigh is permanently flexed is determined by placing the patient flat upon her back and attempting to press the limb down upon the table, in the position of extension. The thigh being flexed upon the pelvis, any attempt to bring it in line with the table will raise the pelvis, leaving a space between it and the table through which one is able to thrust his hand. That is the case in this instance. In fact this patient's symptoms do not justify the assumption of the presence of hip-joint disease. However, we cannot certainly exclude disease of the hip-joint; hence we must say to the parents, if you do not take good care of the child it possibly may develop hip-joint disease. In such cases we have to be most chary and circumspect in prognosis. We will advise the

father to keep the child at rest, and if possible we will practice fixation of the affected limb. After a week or ten days we will examine her again. No harm can be done to the patient by rest and fixation, even if no hip-disease be present. Should, on the other hand, this case be one of beginning hip-trouble, the symptoms of the affection will not fail to appear in time in spite of the treatment, and we shall have the pleasant consciousness of having guarded the interests of our patient.

Lacerated Wound of the Thumb.

We have here a case which would perhaps be looked upon by most of you as a trivial one, but it is not trivial. We have before us a young man of good looks and bright future. You smile, and probably deem my remarks irrelevant. But the consideration of what I said is a part of the true physician's business. I wish to illustrate a point which medical men so often disregard. Here is a young laborer, who depends upon his handiwork, so far as his future is concerned. He has sustained an injury of the thumb. You know that the thumb is the most important of all the fingers. I would rather lose these four fingers than my thumb. Now, if this little wound, which is superficial, which is not very serious, is attended to properly it will heal within a fortnight, and this young fellow will be able to pursue his vocation, to earn his bread, and if he is frugal and ambitious, to save something and rear a happy family. He will be a useful man in our growing country. But suppose that hand is not treated properly? Suppose he should fall into the hands of a druggist who practices medicine, or comes to a doctor, who, although he has a diploma, is also a quack (for there are such); there is considerable hemorrhage, the patient and his friends are scared, the doctor or druggist gets excited, and instead of placing a finger and making pressure upon the bleeding artery, that the hemorrhage may stop; or by ligating the vessel, if pressure be insufficient; instead of doing this, he reaches for the styptic bottle, puts a wad of cotton, soaked in the styptic, on the wound, then covers it with adhesive plaster and a bandage, sends the man home, tells him to come to-morrow and be sure to bring the fee. Now, what takes place? This laborer has injured his hand with a dirty tool. He may be a butcher, and was using a knife which had some filth upon it that was deposited in the wound. The quack has hermetically occluded the wound by applying his styptic. The next day

the patient feels sick; he feels chilly; he has lost his appetite; he has a headache; his bowels are constipated; at night he cannot sleep because his finger is throbbing with pain. Now, if you dress that wound, and succeed in pulling off the mixture of crust, styptic, cotton and adhesive plaster, you will observe that the region of the wound is inflamed and that pus is oozing from it. If the laceration has reached down to the synovial sheath, you will have a lively time with that patient, and the poor patient will have the liveliest time of all. You know that suppurating on the thumb and little finger is worse than if located on any of the other fingers. Celsus and the oldest medical writers, mention the fact, and the common people know that an injury to the thumb or little finger is more serious than an injury to either of the other three. This is accounted for by the anatomy of the parts. The synovial sheath of the three middle fingers consists of two compartments. The one commences at about the middle of the terminal phalanx and extends to the head of the corresponding metacarpal bone. There it ends in a blind sac. From there, the sinew passes through loose connective tissue, and has not a sheath proper for a distance of a quarter to half an inch. Then it enters the common bursa, situated under the palmar aponeurosis, through which all the flexors of the fingers run. Therefore, when suppurating takes place on the three middle fingers, very frequently it perforates spontaneously at a point corresponding to the metacarpo-phalangeal joints where these synovial sacs end. But in the case of the little finger and thumb, the inflammation generally behaves in a different manner. Often we see it jump, as it were, from the finger up to the forearm, and it is for that reason that inflammations of the thumb and little finger have a bad reputation. This is due to the fact that the synovial sheath of the thumb and little finger, although the latter furnishes exceptions, openly communicate with the palmar bursa, which again communicate with the sheaths of the tendons running up the forearm. Therefore, suppurating of the little finger and thumb should be dreaded, and trifling injuries of them be treated with the greatest care. Deep-seated suppurating here may lead not only to loss of the thumb or little finger, but to loss of the arm, and perhaps the life of the patient. Having spoken of the improper treatment of such a case, let us now consider its proper treatment.

You see this man's hand is dirty, as a workman's hand must be. The first thing to be done is to soak it in soap and water,

scrub it thoroughly, and render it clean. Having cleansed the hand, irrigated the wound, and turned out the clots, the question of closing the wound will arise. Is it better to close the wound and seek to secure primary union, or is it better to leave it open to heal in another way? This question is a very important one, and is not always easy to decide. There may be only a small puncture through the skin, but a big gap inside filled with blood clot and filth carried in by a blunt instrument,—such a condition as is frequently seen in compound fractures of bones; fractures accompanied by only a small perforation. A patient, for instance, has been found at the side of the road, lying in the dirt. A kind passer-by sees the distorted limb, and finds a small spiculum of bone projecting through the integument. The limb has been crushed, twisted out of place, is lying in the dirt, and this kind passer-by seeing that something is wrong with the limb, takes hold of it and straightens it, puts it into the straight position. But what has this good Samaritan done? He has replaced that soiled, muddy bone which was sticking out through the integument. Now, that was a poor service. If the bone had first been cleansed and disinfected, and then jerked back into place, it would have been all right. But it was jerked back too soon, that is, it was replaced with all the filth adhering to it. The same thing often happens with small wounds, and suppuration follows inevitably. To avoid suppuration they must be cleansed thoroughly before they are closed, or, if they are to be treated as open wounds, before the dressing is applied. The old time surgeons had, as a rule, better results from severe comminuted fractures, complicated with a large external wound, than from compound fractures with a small external wound. The reason now appears plain; in the first class of cases, to be sure, filth entered the wound, but drainage through the extensive aperture was ample, and the cases often did well. In the latter cases, the small external wound was inadequate for drainage, and if some filth had entered the wound, the destruction wrought by suppuration was appalling. In the former cases there generally is free and ample drainage; in the latter the infectious discharges are retained in the wound, as the small cutaneous wound proved insufficient for drainage. In either class of cases it is of the utmost importance to establish cleanliness, and then, if the larger wound is found too large, it may be partly closed by suture; and, if the small aperture of the integument is inadequate for drainage, that

opening should be enlarged, and supplemented by counter-incisions.

Believe me, it is a great mistake to imagine that a small wound will get well without all that "fuss and feathers," as antiseptics or cleanliness is contemptuously called by some. Some of them, it is true, will get well without attention. But most of them will suppurate and may end seriously. The correct treatment of small wounds is the school wherein to learn to treat correctly larger wounds. If you make a mistake in the treatment of a small wound it may not cost your patient his life, but if the mistake leads to the loss of a limb, it may cost you your reputation.

We find, after thoroughly cleansing the wound on this man's thumb, that it extended just to the sheath of the tendon, but not through it. Now, if we can prevent suppuration, we will have done the man a great service. If we do not adopt measures to prevent suppuration we shall have done him a great harm. To prevent suppuration is the shibboleth of modern surgery.

When, as in this case, the external wound is ample, thorough cleansing and disinfection of the same is easily accomplished. When the wound in the integument is small, and leads to a cavity, it is necessary to enlarge the wound orifice in order to be able to remove dirt or other foreign substances, and to properly disinfect it by mopping out and irrigation. A dressing, consisting of iodoformized and corrosive sublimate gauze is bandaged on the injured part, and now a favorable course of healing may be confidently expected.

White Swelling of the Knee.

Here is a man, aged 32, given to drink, who has come to us on account of a swelling of the left knee. He has the indications of being ill-nourished. He tells us that he once had swelling of one elbow, which he thought was rheumatic, but it festered, and he finally lost the arm by amputation. Now, without any reason known to him, a similar condition is making its appearance at the knee.

What do we notice? First, there is disability to completely straighten and flex the limb. To the hand the left knee feels warmer than the right. The contour of the left knee differs from that of the right. You notice a depression of the patella between two lateral protuberances, which feel doughy, almost fluctuating. The whole joint is intumescent. On palpating it, and after puncture, we find absence of liquid. The phenomenon known

as "ballottement" on pressure over the patella is not noticeable in this case. When the patella is floating a click is produced when it is pressed upon, due to its striking against the underlying condyles of the femur. The general intumescence about the joint would mislead some into the supposition that it was filled with fluid. The essence of this intumescence is to be sought in the thickening of the entire capsule of the joint; a gelatinous imbibition is present, which gives the appearance of fluctuation from liquid. But if we introduce the aspirator we do not succeed in bringing forth any fluid.

You tell me the diagnosis is tubercular ostitis of the knee-joint. I would accept the diagnosis with one qualification. I do not know positively whether ostitis be present or not. My reason for not feeling absolutely certain on this point is the fact that in grown persons tubercular affections of the knee-joint rarely commence in the bone. The common beginning of this trouble is in the synovial capsule. From there, of course, it often extends to the bone, and on opening the joint we find the cartilage destroyed and the bone invaded.

In former times these cases were called the *crux chirurgicorum*—the cross of the surgeon. White swelling was known to be a most intractable complaint, which often led to extensive destruction of the affected joint, necessitating amputation. Local applications, fixation, counter irritants, were all more or less ineffective. Our knowledge of the pathology of this complaint has led to the development of a rational therapy. If the case were that of a child, you would at once see that proper hygienic regulations were carried out; you would see that the joint was put at rest, but in such a way that the patient could take at least a moderate amount of exercise. For this purpose you would apply Taylor's or Sayre's apparatus in the manner so admirably demonstrated at his clinic by Professor Gibney. But in the case of a grown man we cannot procure apparatus which will support his weight any great length of time; and the cases which come to dispensaries are unable to bear the expense of frequent repair and renewal. If made strong enough to sustain weight and wear well, the patient will object to its cumbrousness. Orthopædic treatment is out of the question for many other reasons, among which is the fact that the patient cannot be idle, nor can he gain admittance to a hospital for a term of a year or two years.

Formerly, if the patient would consent

to it, the surgeon put the limb up in plaster-of-Paris, or some other form of apparatus, and kept it confined. The limb had to be spared as much as possible. Perhaps in a year or two ankylosis did result, and the patient was cured at the loss of mobility in the joint. When he could not afford to keep the limb in plaster-of-Paris, or some apparatus, but went about as well as he could, using the limb and trying to earn his bread, often cold abscesses formed and fistulous openings leading into the joint established themselves. In such cases the older surgeons took the knife and cut off the limb. That course of things we see has been illustrated in this patient's arm. But at present we do not amputate unless the suppuration, the formation of fistula and destruction of bone, but especially of the soft parts, has gone very far. In cases like the one before us, with tuberculosis of the knee, we do not amputate—we excise the joint. The results in grown subjects are very good. Exsection of the knee-joint before the formation of fistula gives the patient infinitely better chances than when the operation is postponed until after the formation of fistula. So, in cases of this kind, the patient belonging to the laboring class, I always propose, as soon as I learn that the disease is not amenable to application of cold, rest, etc., exsection of the joint. I do not hesitate to propose such an operation, because I feel that it involves comparatively little danger, and it offers a good chance of eliminating the tubercular focus completely. The patient will afterward have a stiff knee, but the limb will be useful. It will not require constant repair, as a cork limb does. All that is required is a thick sole on the shoe. All of the patients on whom I have performed the operation have afterward been grateful that it was done. We should hesitate much longer before advising exsection in children, for in them the limb has not completed its growth. As you will remember, the growth of the lower extremity takes place from the epiphyses near the knee, and exsection of the epiphyses here finally results in considerable shortening. My first exsection of the knee was performed, about ten years ago, on a child three years of age. I saw that child lately, and found that the limb operated upon is about four inches shorter than its fellow. The case was treated by apparatus, by making incisions and counter-incisions, and such other means as would, if possible, save the joint. But this proved unavailing, and exsection or amputation had to be thought of.

You ask me whether I would exsect the joint if there is pulmonary tubercular infiltration? I have performed exsection of the knee-joint about sixteen times, and I do not think there were more than two cases of the sixteen in which there was no infiltration of the apices of the lungs. And in all of these cases there has been a marked improvement of the general condition, because of the elimination of one focus of disease at least. There are several reasons for the improvement which follows removal of the diseased bone. First, we take away a source of danger to life by stopping a constant drain to vital force. Secondly, as long as the local disease exists the man can take no exercise. By putting him in a condition to take exercise his appetite improves, he begins to sleep well, his muscles grow stronger, he becomes a new man; his lung trouble may not be entirely cured, but he ceases to cough, and the progress of the pulmonary tuberculosis is checked.

The method of operating will have to be considered at a future clinic.

ORIGINAL COMMUNICATIONS.

A GROUP OF CASES ILLUSTRATING SEVERE INFLAMMATORY AFFECTIONS OF THE CORNEA, IRIS AND CONJUNCTIVA, AND THEIR TREATMENT.

BY G. E. DE SCHWEINITZ, M.D.,

Ophthalmic Surgeon to the Philadelphia Hospital.

The group of cases recorded below present no new features; but they illustrate the value of certain lines of treatment, even when the outlook is most discouraging, and they warn against the dangers of inappropriate, though commonly employed methods of medication.

Granular Lids; Abscess of the Cornea.

Maggie C., aged 25, born in Italy, was admitted to the Eye-Wards of the Philadelphia Hospital on account of granular lids, most marked in the right eye, in which there was pannus, and just below the centre of the pupil a small, gray ulcer. Slight muco-purulent discharge and marked photophobia completed the symptoms. The topical remedies ordered were atropine drops and a solution of bichloride of mercury (1-8000), and internally, quinine and iron after the patient had been properly prepared by the administration of a mercurial purge and the daily use of

sulphate of magnesia. The left eye rapidly improved; the right did not, but the gray ulcer increased until the lower part of the cornea was occupied by a large abscess. The photophobia was most aggravated; the pain intense. A broad needle was passed through the abscess and into the anterior chamber, evacuating the contents of both. Hot water compresses, the water of a temperature of 120° F., and the applications made for ten minutes at a time every two hours, were ordered, and the internal treatment above described was continued. The results were most happy; the pain was instantly relieved, the photophobia diminished, and the slough in the cornea separated. A large ulcer, shallow except at one spot, where Descemet's membrane bulged forward, remained. The hot water was discontinued and a pressure bandage applied, under which the cure was completed, leaving an irregular scar which was fortunately below the pupil. The granular lids had improved also during this time, and, when the active and dangerous inflammation of the cornea had subsided, were treated with the usual remedies.

Ulcerative Keratitis; Hypopyon.

Jas. B., aged about 45, was admitted to the wards, with his eyes in the following condition: The right cornea was occupied by a dense, adherent leucoma, the result of former inflammation and ulceration, and was practically sightless. In the lower third of the left cornea there was a deep, irregular ulcer, and the bottom of the anterior chamber contained a good-sized collection of pus, whose upper level was a horizontal line. The patient was anæmic, and had upon his body the evidences of syphilitic infection—a specific leg-ulcer and numerous copper-colored cicatrices at the seat of former ulcerations. He gave a perfectly clear history of the initial infection, which had been followed by secondary lesions years before. This eye-lesion came on after exposure following a debauch. The bowels, which were constipated, were thoroughly moved with blue mass and sulphate of magnesia, and the man put upon twenty drops of the tincture of the chloride of iron and $\frac{1}{4}$ of a grain of bichloride of mercury, thrice daily. The hot water compresses, in the manner before described, were ordered; together with atropine drops and antiseptic washes. In twenty-four hours the hypopyon had so much cleared up, and the ulcer become so much less angry, that paracentesis of the anterior chamber was not deemed necessary. The recovery was uninterrupted, and the resulting scar was suf

ficiently below the pupillary space so as not to seriously interfere with useful vision.

Kerato-Iritis; Hypopyon. Two Cases.

Case I.—P. S., aged about 45, an Irish carter, came into the wards on account of kerato-iritis of the right eye. He had extensive ectropion of both lower lids and an adherent leucoma of the left cornea. The present attack began about ten days before he sought admission. The lower half of the anterior chamber was filled with pus, the entire cornea was hazy, and the iris discolored and attached to the capsule of the lens (posterior synechiæ). Severe brow and temple pain, and slight febrile reaction were present. The man denied syphilis and gave exposure as a cause of the inflammation. He was purged, put upon alterative tonics, and locally, atropine drops, bichloride of mercury collyrium, and hot-water compresses—the latter after the anterior chamber had been opened and the pus as far as possible removed. After a few days when, by the aid of the tonics and milk punch, the nutrition had improved, the former were stopped and iodide of potash in ascending doses ordered. The result was entirely satisfactory, and a useful cure resulted.

Case II.—John L., aged about 40, came to the wards suffering with a kerato-iritis of the right eye, complicated with hypopyon; in all particulars similar to the last case. The man was a hard drinker, had had syphilis and the inflammation had appeared during a prolonged debauch. The same treatment as in the last case was ordered, and, as there was marked insomnia, large doses of bromide of potash at night. Relief followed these measures, but the restlessness and brow and temple pains continued. Three ounces of blood were then drawn from the temple, and the pain diminished; but during the night the full symptoms of delirium tremens manifested themselves. Bromide of potash was then given freely during the day, and chloral and morphia at night. The attack subsided readily, and at no time during its continuance did the eye-symptoms grow more aggravated, the topical treatment having been industriously applied. The eye gradually cleared up, and the appearances returned to well-nigh normal, with the exception of several synechiæ, which did not tear loose under the atropine.

Serpiginous Ulcer of the Cornea Occurring in a Very Old Man.

A. J., aged 85, an inmate of the hospital on account of chronic nephritis, came to the

Eye-Ward for the following reasons: A few days previous to his admission, he was attacked with a slight conjunctivitis of the left eye, and this was treated with some simple astringents. During this time, it was thought, a foreign body entered the conjunctival cul-de-sac and abraded the cornea. Very quickly the eye took on an active and dangerous inflammation and, when he applied for treatment, presented this appearance: swollen and rigid lids, tarsal conjunctiva opaque, bulbar conjunctiva slightly thickened, and surrounding the cornea a dark red zone of congestion. The cornea was hazy throughout and lustreless like "that of a dead fish," while below there was an irregularly crescentic ser-piginous ulcer, to the outer side of which there was a yellow line, indicating a collection of pus between the lamellæ of the cornea. Severe pain accompanied the local condition; the tongue was dry and furred; the bowels constipated. The treatment consisted in the administration of saline laxatives, Bashams' mixture, and milk punch occasionally. The eye was kept clean with a saturated solution of boracic acid, atropine drops were instilled, and hot water compresses applied. At first, the latter were used for ten minutes at a time four times daily, and later, for the same length of time, every two hours. This case, considering the circumstances and the age of the patient, has done well, and the dangerous local manifestations have in great part declined. The old man is still under treatment, but there is every reason to believe the result will be a useful eye.

Purulent Ophthalmia; Ulceration and Perforation of the Cornea. Two Cases.

Case I.—Margaret S., aged 30, the mother of five children, was admitted to the wards during the latter part of August. She had only tolerable health. There was no vaginal discharge and no history of infection from a specific source. About three weeks before admission, after a long night's sewing in an ill-favored and badly-lighted room, she was attacked with muco-purulent conjunctivitis of the left eye. Upon this, she tied the eye up with poultices of tea leaves, and, as it continually grew worse, she substituted for these one made of linseed meal. Under this treatment, the inflammation rapidly took on the purulent form, and one week after the left eye was affected, its fellow was similarly attacked, but, fortunately, less actively submitted to domestic medication. When examined at the hospital, there was great œdema of the lids, swollen and thickened conjunctiva, which freely secreted pus, and

on the left side a large perforation of the cornea into which the iris had prolapsed, and from the upper part of which a button of turbid vitreous was protruding. The eye-ball was soft, intensely tender, and partly collapsed. In the upper part of the right cornea there was a broad, semilunar ulcer of the serpiginous type, extending almost through the entire thickness of the cornea. The woman was suffering with intense pain in the eyes, especially the left, and violent throbbing pain in the left side of the head. The temperature was above normal. In spite of the existing panophthalmitis, the shrunken left ball was removed, the pain was directly relieved, and the temperature returned to normal. Frequent cleansings, with antiseptic solutions, atropine and hot fomentations, constituted the treatment of the right eye. This rapidly improved in its appearance, and all but the inner end of the semilunar ulcer healed up. At this point, however, during one night, perforation took place, with prolapse of the iris. A pressure bandage and eserine drops failed to decrease the size of the hernia. The sac was hence opened, the prolapsed iris seized, drawn slightly outward, and cut off. The bandage and eserine were continued. Thus far, the eye has done well, and through the resulting egg shaped pupil there is useful vision. That the eye was saved at all was a matter of congratulation. The internal treatment was quinine, iron and milk punch, with due attention to avoid constipation.

Case II.—Maggie B., aged 28, unmarried and a servant in a large sea-side hotel. Her work was washing and she was constantly exposed to wet and damp. She was a somewhat flabby, large-framed woman, of fairly good general health, and suffering from slight leucorrhœa. Seven weeks prior to her admission both eyes were attacked with ordinary conjunctivitis. She continued her work, and during the day bathed her eyes with iced tea, and at night tied them up with warm poultices of bread and milk. *Pari passu* with this treatment the eyes steadily grew worse, she soon was unable to attend to her duties, and when she came to the hospital she presented the following pitiable condition: The conjunctivas were fleshy, thick and covered with pus. The corneas were deeply ulcerated, perforated, and the apertures of the perforations occupied by prolapse of the irides and granulations. On the left side, the vitreous was freely escaping. The eyes, of course, were spoiled and sightless. Fortunately the woman suffered little or no pain. Antiseptic cleansings, atropine

and warm fomentations reduced the inflammation; but it was too late to save or restore sight to this unlucky woman.

REMARKS.—It is perfectly evident that the saving means of treatment in the cases of abscess of the cornea and hypopyon were the hot water compresses and incision of the cornea, with removal of the pus as far as that was practicable. Hot water as a method of combatting inflammatory diseases of the eye is by no means a new treatment, and only quite recently it has been deemed a worthy subject of papers presented to societies specially engaged in the consideration of eye surgery. The water should really be hot (120° F.) and the compress changed frequently enough to maintain this temperature. Otherwise applied the treatment may do harm. No matter how accurate the local treatment of an eye inflammation may be, the surgeon must not neglect the patient's general state. In syphilitic patients the temptation is at once to resort to the recognized anti-syphilitic remedies—mercury and iodide of potash. It should be remembered, however, that in those individuals who are the subjects of advanced syphilis, and in whom anæmia and cachexia are dominant symptoms, these remedial agents are sometimes productive of positive harm, always excepting the cases in which the lesion endangers life. In these cachectic patients the combination of tincture of the chloride of iron and bichloride of mercury is often a happy prescription. The case of keratoiritis with hypopyon, in which delirium tremens occurred as a complication, without interfering with the progress to recovery, is worthy of notice. It is interesting to observe that, while the prodromes of this attack of *mania-à-potu* were present at the time of the man's admission, the full development only appeared immediately after the cupping of the temple. The abstraction of blood acted as an exciting agent. The two instances of purulent ophthalmia are quoted because they are sad illustrations of the pernicious practice of tying up eyes, which are the seats of catarrhal inflammation, with warm poultices. Mr. Nettleship, in his admirable book on "Diseases of the Eye," has italicized this sentence: *The eyes should not be bandaged in any form of ophthalmia, and poultices are very seldom necessary.* It is a pity that this advice could not long ago have been italicized upon the minds of many people. Had it been possible fewer blind eyes would exist in the world to-day. The result in the case of the old man, the subject of serpiginous

ulceration of the cornea, was certainly gratifying, because of the dangerous character of the ulceration and the age of the patient. While atropine in this instance acted happily, it should be remembered that often in these cases, when the sclera is stiff or the tension above normal, sulphate of eserine is the more useful drug. It should be used in the strength of one grain to the ounce. It acts probably by decreasing the intraocular tension. The people in whom these eye lesions occurred were without exception the owners of depraved constitutions, an ownership that had either come by inheritance or else through a wilful or unavoidable disregard of the laws of health. They were all unfavorable subjects to work upon, and the fact that in most of the instances the result was fairly good, indicates the value of the methods employed. A distinguished medical teacher, when lecturing upon the management of opium poisoning, was accustomed to say: "Never stop treating your patient until he has been dead for some hours." Thus did he endeavor to impress upon his hearers that intelligent efforts often succeeded in resuscitating the poisoned individual even when all hope had departed. In like manner, it seems to me, thoughtful and careful treatment of an eye should not grow weary, even though that eye be upon the very threshold of blindness. The result will often be good when least expected.

1330 Spruce Street.

INFANTS' FEEDING BOTTLES.

BY W. M. POWELL, M.D.,

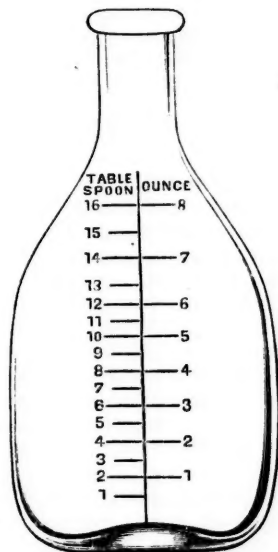
One of the Attending Physicians to the Children's Dispensary of the University Hospital, Philadelphia.

Prof. Louis Starr, in his lecture on Artificial Feeding, at the University Hospital, laid special stress on the proper kind of nursing-bottle to be employed. He exhibited three styles before the class, as follows:

First, the English nursing-bottle, which consists of a twelve ounce bottle with a perforated cap, which screws to the neck, through which passes a glass tube about six inches long; to this tube is attached a soft rubber tube about sixteen inches long, with a rubber tip at its extremity. The objections to this bottle are numerous. It is impossible to keep the glass as well as the rubber tube clean, the spiral turn around the neck of the bottle to which the cap is screwed is a resting place for dirt,

the bottle has too many angles and corners, which are difficult to keep clean. This bottle should never be used under any circumstances.

The second bottle shown was the ordinary eight ounce nursing-bottle without the rubber tubing, and simply supplied with a soft rubber tip. This bottle also has its objections, the sides and bottom meeting at an angle in which milk is apt to accumulate.



The third bottle shown (see cut) was made according to the suggestions of Prof. Starr. It is called the *Graduated Nursing Bottle*, and is made of transparent flint glass, thus showing plainly the slightest foulness at a glance. The interior surface is made entirely free from angles, and an accurately graduated scale of fluid ounces and half-ounces or tablespoonfuls is blown in the glass. This bottle will be found very convenient, accurate in measurement and easily cleaned, thus combining the conditions so essential to the successful hand-feeding of infants.

2205 Pine St., Phila., Nov. 18th, 1887.

—Scarlet fever has been remarkably prevalent in Boston during the last few weeks. There are probably about sixty cases at present in the city. Dr. Durgin, of the Board of Health, is reported as saying that he has no doubt but that the digging up of the streets had considerable to do with the increase in sickness.

CHLOROFORM IN SPASMODIC CROUP.

BY H. V. SWERINGEN, A.M., M.D.,

FORT WAYNE, IND.

On the night of Oct. 10, 1887, I was called in great haste to see a four year old boy, Klepper by name, whom I had upon several occasions treated successfully with emetics for spasmodic croup. The present attack, however, was more severe than any of his previous ones; and the usual dose of the solution of sulphate of copper, which had been already administered and followed by copious vomiting, proved of no benefit. Upon my arrival I found him apparently in a dying condition, completely cyanosed and almost comatose. The parents, although accustomed to seeing him and others of their children in similar attacks, were unusually alarmed at his frantic efforts to breathe, which were horrible to witness, and had called in the neighbors for what assistance they might render. A cloth wrung out of cold water had been wrapped around the child's neck, after vomiting, but without any benefit. I expressed the opinion that he would get better in a little while from the vomiting, which, in all prior attacks, had sufficed to relieve him, and generated fumes of tar and turpentine by placing some of these drugs upon the surface of water kept constantly boiling on a small coal-oil stove. But no relief came; on the contrary, he seemed to be growing worse, if that were possible.

I had a bottle of chloroform in my pocket, and, although it hardly seemed appropriate for a cyanosed condition, I concluded to see what it would accomplish. I always use chloroform for the relief of asthma, and why not use it for the relief of croup, which is similar in my opinion in its effects and calls for the same treatment? In the present instance the result was most gratifying, for the boy was speedily relieved, and has since made a good recovery.

SMALL DOSES.

BY JOHN AULDE, M.D.,

PHILADELPHIA.

That there is a tendency on the part of physicians to discontinue polypharmacy, and depend more and more on single remedies (specific medication), and prescribe smaller doses, no one will contradict. The innovation is commendable, and is one of the most promising features of the times. As a com-

plement, then, to the paper on "Large Doses," which appeared in the *REPORTER*, Nov. 5, 1887, I beg leave to submit the following remarks:

In certain heart affections, such as cardiac dilatation, one or two drops of the tincture of digitalis may be given three times daily with great benefit. Cardiac hypertrophy, on the other hand, may be materially overcome by the exhibition of one drop doses of aconite tincture three times daily. Acute inflammatory conditions, like tonsillitis, bronchial catarrh, and threatened pulmonary congestion, as well as headache due to arterial tension, are immediately and favorably affected by drop, or half-drop, doses of tincture of aconite every hour, or half-hour, for a few hours. Frequently, headache of the congestive variety, with a band-like feeling around the forehead, may be quickly relieved by drop doses of nitroglycerine, at intervals of five or ten minutes, until five or six drops are taken. The form known as "sick headache," dependent on a bad condition of the stomach, will often disappear in half an hour under the influence of two grains of potassium iodide dissolved in water, and taken in divided doses at intervals of from three to five minutes. Like aconite and nitroglycerine, gelsemium occupies an important position in cases of this class; but its uses are not so well recognized as that of the other drugs named.

Belladonna, or its active principle, atropine, in doses of one two-hundredth of a grain, is a valuable remedy in the incontinence of urine of children, a single tablet of that amount dissolved in water and taken at bedtime being often all that is required. Quinine, in doses of one-tenth of a grain, may be given to those who are unable, on account of idiosyncrasy, to take larger doses, and it will often be found that these small doses are sufficient. The tincture of hyoscyamus, in doses of from three to five drops, or one drop of the fluid extract, in combination with *tritium repens*, made up in the form of a hot tea, is an admirable remedy in cases of irritability of the bladder, with fugitive neuralgic pains about the abdomen and in the lumbar region.

In the treatment of certain classes of dysentery, a modification of Hope's camphor mixture will be found of signal service. The dose may be limited to two or three drops of the deodorized tincture of opium, with an equal amount of dilute nitric acid, or aromatic sulphuric acid, with sufficient camphor water to make a teaspoonful, and taken hourly or half-hourly, as the circumstances seem to

demand. In similar cases, where it is desired to produce an effect on the alimentary canal with a view to getting rid of objectionable matter, a single grain each of opium and ipecac may be combined with four grains of blue mass, and divided into eight parts, one part to be taken every hour, or half hour, with the happiest effect.

The malate of iron in minute doses is an excellent remedy as a tonic, and Bland's pill, one three times daily, is often sufficient in cases of anemia, although it is usually stated that the dose should be from four to six pills. Small doses of nux vomica, one drop of the tincture, or one-twentieth grain of the extract, are frequently as serviceable as a tonic as the larger doses; while strychnine in doses of one-sixtieth to one one-hundredth of a grain, will accomplish all that is desired, when the stomach is in a suitable condition, and is much better, as it is much safer, than larger doses. In some cases of diarrhoea, five grains of bismuth, with an equal quantity of saccharated pepsin every two hours, acts like magic.

Dysmenorrhoea, the congestive kind, with belly-ache and excruciating headache and pain in the back, which is often seen in young girls, and women with displacements, can often be relieved by a single dose of ten drops of chloroform on a lump of sugar. Certain cases of this nature seem to do better with cannabis indica, and I have seen cases, which had resisted ordinary treatment for days, wholly relieved in an hour by the use of half-drop doses, at intervals of five minutes. Cannabis indica is a favorite remedy in trifacial neuralgia, and given in the manner indicated above, the pain will shortly disappear. Profuse diaphoresis may be produced by the frequent administration of half minim doses of extract of pilocarpus. Phosphorus, in doses of one one-hundred-and-fiftieth of a grain, given three times daily, will produce such an effect that it may be tasted by a susceptible patient for several days afterwards. Morphine in tablets containing one-fiftieth of a grain can be given in many instances with marked benefit. One drop of a one per cent. solution of the fluid extract of rhus toxicodendron is often an efficient remedy in stubborn attacks of sciatica and other affections of a like character. One-tenth of a grain of calomel, given every hour, it is well known, will produce an effect on the bowels equal to ten grains given at one time. Corrosive sublimate, one-fiftieth of a grain three times daily, is an excellent remedy in disease of the stomach with fermentation and eructations of gas. It is doubtful if we

have any better remedy for the treatment of boils and carbuncles than small doses of calcium sulphide, one-tenth of a grain every two hours. Last, but not least, is stryphanthus, the heart tonic *par excellence*; two to five drops of the tincture should be given three times daily, in all cardiac affections where there is aortic or mitral insufficiency.

4719 Frankford Ave.

SOCIETY REPORTS.

NEW YORK ACADEMY OF MEDICINE.

SECTION IN OPHTHALMOLOGY AND OTOLGY.

Meeting of November 21, 1887.

Sarcoma of the Iris.

DR. HERMAN KNAPP presented the specimen and said: "Sarcoma of the iris is so rare a disease that the publication of even a single case need not be introduced with apology. The case was a well-marked, I may say a typical, example of this disease. It occurred in the left eye of a lady 53 years of age. Three and a half years ago she had a fibrous tumor removed from the lobule of the left ear. This tumor recurred, and was removed one year since. There has been no relapse noticeable so far. Four months ago she was first aware that the sight of her left eye began to be impaired; that a small colored tumor developed in the iris and encroached on the pupil. The growth had increased rather rapidly, and the eye was at times painful and congested. When she presented herself, September 8, 1887, the eye was free from irritation, of normal size and tension; but its vision was reduced to perception of light with perfect localization of the candle. At the outer, upper part, the iris was replaced by a reddish tumor, the size of a cherry-stone, extending over the adjacent third of the pupil. The iris was otherwise normal. There was adhesion of the pupil all around. The lens was cataractous. There was no increase of tension. There was at that time no other inflammatory disease perceptible. The eye moved freely, and was not painful. The other eye was healthy. The patient appeared to be free from any other complaint.

The diagnosis, sarcoma of the iris, being evident, the question arose, Can and shall we remove the growth and spare the eyeball, or shall we remove the whole eye? Having operated successfully in three cases and assisted Dr. Kipp in another, I thought of

saving the globe; but, on further reflection, I determined to remove the eyeball, chiefly for the reason that the pseudoplasm had damaged the adjacent structure so much as to make preservation of useful vision almost impossible.

The patient consented to enucleation, which was done without accident, and was recovered from in a few days. She has not had any discomfort since. The tumor proved somewhat larger than the displaced crystalline lens. It was elliptical: eight millimeters long, five millimeters broad. The tumor was completely circumscribed, and occupied the iris or the ciliary pupillary margin. Its front surface was covered by a thin layer of iris. Its starting point seemed to have been situated in the root of the iris, quite near the ciliary process. Its surface was smooth. It could be separated from its surroundings everywhere except at the attachment of the ciliary margin to the inner wall of Schlemm's canal. Its cut surface was white; it was coherent and moderately hard. Besides displacement of the lens obliquely into the vitreous, nothing remarkable was observed in the other part of the eye.

On microscopical examination, the growth proved to be a typical specimen of vascular round-celled sarcoma. A rich network of blood vessels with delicate walls pervaded the whole tumor. The diagnosis was primary, tubular, round-celled sarcoma of the iris.

Remarking further upon the case, Dr. Knapp said that these tumors are malignant. He had in three cases removed a sarcoma of the eye, only one of which had remained under observation. The tumor was removed in 1876. It had grown slowly, caused iritis several times before the operation; twice since; but since then the eye had remained free from irritation. Since an operation on the eye for cataract, the sight had remained good. The growth was a melanotic spindle-celled sarcoma; less suspicious than the round-celled, vascular growth in the case just related.

Dr. Knapp had been able to find but twenty one cases of sarcoma of the iris reported in medical literature, excluding the one just related. The diagnosis was principally from melanotic nævi. These latter might pass over into sarcoma. Speaking of the operation for removal of the growth, sparing the eyeball, Dr. Knapp said he would not hesitate, after its removal, to go in and cauterize the ciliary body; the action of the galvano-cautery would be entirely local.

DR. WEBSTER and DR. ANDREWS recalled a case of sarcoma of the iris operated upon by Dr. Agnew about six years ago. The pain following removal of the growth necessitated enucleation a few days later.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, November 9, 1887.

The President, J. SOLIS COHEN, M.D., in the chair.

DR. DEFORD WILLARD read a paper on **Foreign Bodies in the Urethra and Bladder. Removal by Litholapaxy Evacuator with Large, Straight, Open-ended Canula.**

My object in bringing before you the subject of urethral and vesical foreign bodies is simply to emphasize the value of the evacuator (ordinarily used in rapid lithotripsy to extract the calculous fragments) for removing other more or less solid substances that have found their way into the urinary tract, either by accident or design.

Foreign bodies enter by various routes. Projectiles may reach the viscus and remain in its cavity; bones may be driven in by crushing forces; fetal remains may ulcerate through from extrauterine cavities; intestinal contents may occasionally make their way into the bladder, but all these are either rare, or are accompanied by such traumatism that death frequently ensues.

The bodies that we will especially consider are those introduced through the meatus urinarius, urinary calculi being only incidentally considered.

The strong tendency for manipulation of this part of the body that exists from early childhood to decrepit old age, leads to many instances of misadventure. Think of a lad actually sliding a watch-chain down his urethra. Examples of inserted beads, pebbles, sticks, etc., are numerous in childhood. After puberty the tendency becomes more marked as the sexual desire increases. A few years later we find the morbid recluse, especially among the shepherds and monks of former centuries, resorting to intra-urethral stimulation with sticks or other hard substances to arouse the over-exhausted functions, waning from excessive masturbation or venery. Yielding himself to his vile erotic feelings, the instrument often slipped from his fingers and was lost in the canal. Sexually insane must have been the shepherd who

had used for this purpose his pocket knife, after manual friction and urethral stimulation had proved unsatisfactory, until little by little, through hundreds of these indecent acts he had laid open the entire penis along its dorsal aspect until the pubes were reached, and the penis hung in two halves, united only by the lower wall of the urethra. Then with a short stick he was able to tickle the very orifices of the ejaculatory ducts. This stick, slipping into his bladder, became encrusted, and it was not until the pain became torturing, that he confessed the cause. Pipe-stems, pencils, thermometer tubes, glass rods, straws, needles, wires, twigs, hairpins, fruit stones, and even forks and lockets, have all been found in the urethra, after introduction for stimulative purposes, or to relieve dysuria from stricture or other causes. In one instance¹ a man introduced a sewing needle of the girl whom "he desired to fall in love with him."

At the present time we have fewer of these lecherous accidents, save from drunken debauchees, but the majority of instances occur from the use of old or improper catheters or bougies. Of course, these accidents are more frequently found in men than women, as the former are more subject to urethral disease, and are also more erotic, but there are instances in both sexes.

In children, small round bodies, as beads, etc., are found in the anterior part of the canal, while the longer instruments at all ages slip back to the membranous portion of the tube, or into the bladder.

Usually a long foreign body will find its way into the bladder in a few hours; rarely, two or more days may be required. In exceptionally rare cases, rounded bodies remain a long time in the urethra, the urine following a tortuous course around them, and, becoming encrusted, a pocket ultimately forms, or suppuration ensues.

It is not strange that catheters and similar instruments are broken off in the canal when we learn of the recklessness of a man who used one gum catheter for twenty years, or of another who attached two portions of a silver tube simply with sealing wax.

A too short instrument has often eluded the grasp of the surgeon and slipped backward.

As to this recedence of instruments, which is strong and actual, there have been many theories. It does not seem strange to me that the compressor muscular fibres of the urethra, when stimulated to action by a

body applied in front, should reverse their usual action as easily as do the muscles of the pharynx, œsophagus, intestines, etc. This act of swallowing a hard substance is aided by the erection of the penis, which in its subsidence (should the anterior end of the object become engaged), drives it further and further back with each successive engorgement. Tending to the same unfortunate end are all the manipulations of the part, in the patient's endeavor to extract the offending body.

Unfortunately for the safe extraction of these bodies, the surgeon has to meet with a large amount of deception upon the part of the patient, when the object has been self-introduced, and it is often impossible to obtain any reliable information either as to the presence of the foreign mass or as to its conformation. In broken bougies the surgeon should, if possible, have the other remaining fragment in his hand for measurement, or else secure one of similar size. Any object of peculiar shape should be accurately described, or duplicated. It must be remembered, that while a patient may confess to the introduction of but one body, there may be several. The position in the canal must be thoroughly fixed. In the ante-scrotal region this is easily accomplished, and with the aid of a sound and a finger introduced into the rectum even the posterior urethra can be well examined, provided inflammation be not too severe. When possible, no manipulations should be attempted for extraction without the body being firmly secured from further recedence.

Ether is of the greatest value, but cocaine injections may answer for urethral work.

Treatment.—About one-tenth of inserted foreign bodies will be spontaneously expelled, but when the *vis à tergo* of the urine fails to wash out either a calculus or an object inserted through the meatus, the safest and surest plan is to attach to an ordinary litholapaxy evacuator (Bigelow's or other improved pattern) a large, straight tube, which is open at both ends. It contains a movable stylet for ease of introduction. The size should be the largest that the urethra will possibly admit (after nicking the meatus, if necessary), say French No. 29 or 30; American, No. 19; English, No. 16, for adults; children in proportion. The possibility of the passage of the body through the tube should be determined, if possible, by actual trial, provided a similar piece can be obtained. Rarely will any bougie larger than the above named sizes be found in the bladder or urethra.

¹ Poulet: Foreign Bodies in Surgery.

The method has been so satisfactory in my hands, as is proven by the collection of objects before you, that I always resort to it with confidence, to the exclusion of all other primary devices.

If the lodgement has occurred in the urethra, the canal must be firmly closed by finger pressure behind the object, while the metallic tube is slid down and carefully caused to engage the catheter or other mass within its calibre, when the bulb of the instrument is slowly compressed until the water has distended the urethra to its fullest limit, thus liberating the body, when suction is suddenly applied while the penis is stretched forward. Unless the mass be firmly caught and embedded in a pocket, this manœuvre rarely fails after a few trials. The quantity of water that can be contained in the urethra is so small that the body may require two or three efforts to withdraw it the whole length of the instrument. The water should be ejected very slowly, but the suction current must be made forcibly. Inspection of the rubber tube can be made through the upper opening without detachment of the catheter.

Avoid employing forceps until unsuccessful with the above method, but when necessary to be used, the superiority of the canula again asserts itself. The forceps can be manipulated through its calibre, and if the object be compressible enough to pass the bore, withdrawal can be accomplished without the slightest injury to the mucous membrane. Objects of larger size than this tube can seldom be withdrawn with safety by any method save cutting. Hairpins can be compressed through the walls of the urethra, and their points passed into the calibre, when they can be completely pushed within the bore and easily withdrawn.

Beads, peas, pebbles, etc., will easily enter the canula by suction. Catheters, wires, etc., will usually require the assistance of forceps. Barbed heads of grain can also be ensheathed and withdrawn by this device.

If the object has passed into the bladder, the evacuator becomes an even more essential aid. A straight instrument is not always easy of introduction, but the security gained against subsequent urethral injury abundantly repays for the trouble. If a flexible or spirally cut obturator is used, the introduction is rendered much easier. The tube is used first as a sound to discover the offending body, when the bulb of the evacuator is first slowly compressed, so as not to disturb the fragment. Suction should always be made quickly, so as to draw the body with force. Failing, the water is next ejected with more energy, so

as to move the fragment into better line with the calibre, suction being again rapidly applied. The hard substances will not be driven against the sides of the bladder with any more power than are calculous fragments, and unless consisting of broken glass will not be as angular. If the body is rounded, and of a size that can pass the bore, it will in a few moments be found in the bulb. If very long, like a catheter, or pencil, or wire, the chances are not so good that it can be brought into line with the calibre of the tube. As a bougie ordinarily breaks at or near the eye, however, its passage is more than probable. Failing, after ten minutes of gentle trial, a lithotrite should be introduced if the body is a bougie or pencil, and is capable of being cut or pinched in two, and the division made. A cutting lithotrite, like Caudemont's, is manufactured, but I presume is seldom found among the paraphernalia of surgeons, and the fenestrated instrument of Thompson is far safer. If the bougie is old and brittle, as is presumtively the case, such division with a lithotrite is easily accomplished. The segments can then be sucked out, and their total length carefully compared with the remaining portion or lost body. Every particle must be secured, lest it form the nucleus of a future calculus. Even the broken jaw of a lithotrite might be drawn into the bore.

If the surgeon has not the straight tube with open end, which I advise, he may use the ordinary straight evacuating tube. Rounded bodies, and pieces of bougie small enough and flexible enough to enter the side opening can often be secured with ease, but long or rigid pieces can only be drawn through the open-ended tube. This tube has the disadvantage that the point must be kept just inside the neck of the bladder. If pushed too far, the posterior bladder wall flaps against it; if withdrawn too much, it is concealed in the prostatic portion, and makes no suction upon the vesical contents. Its safety from impaction of fragments in the eye, however, more than counterbalances this slight trouble; since, in the ordinary evacuating tube, a large fragment often cannot be dislodged from the eye, and lacerates the urethra during withdrawal.

Should these manipulations fail (and, if they have been carefully conducted, no injury need have been done to the bladder), I show you how two forms of forceps which I have had made of just sufficient length to be slightly protruded from the end of the tube. In the one the jaws open by a spring, as in the old Halles forceps; and in the

other the jaws are worked by handles, as in the Mathieu and Gross and "alligator" patterns.

Careful attempts can now be made to seize the body and extract it through the catheter. If small enough to be brought through, it is a great satisfaction to know that no possible injury can be done to either the neck of the bladder or the urethra, as is so likely to occur when a body is extracted in the jaws of a lithotrite. Necessarily, only a small proportion of introduced objects can be removed per urethram; and I should lay it down as a rule that any foreign body too large to pass the calibre of this No. 29 tube, unless it be very soft and pliable, should be removed by lithotomy, either perineal or suprapubic. Lithotomy has its dangers, but laceration is worse.

The suprapubic is at present the fashionable operation, and it certainly presents many inducements in its favor. The median perineal operation, however, is a safe one, and gives excellent results. No important structures are severed, and there is seldom troublesome hemorrhage if the raphe is closely followed. By either of the routes, great care must be exercised in the search if the object be sharp-pointed, lest a perforation be made. The inflation of the rectum in order to lift the bladder must be dispensed with if the object is sharp-pointed. The upper route gives more room, and, while there is a slight risk of wounding the peritoneum, yet we must remember also, in the extraction of large objects as well as calculi by the perineal route, that the rectovesical fold of the peritoneum is in close proximity to the neck of the bladder, and may not escape involvement in the subsequent inflammatory action.

If the walls of the bladder were only of sufficient strength to warrant their immediate sewing with catgut or silk, and permit primary union under strictly antiseptic dressings while the urine were drained off below, the suprapubic route would certainly be decidedly the better one; but, as this is not the case, there is still room for honest differences of opinion in the selection of an operation. For the present, we must be content to drain the suprapubic wound.

In the absence of an evacuator, the expulsive force of the urine is often sufficient to dislodge a urethral impaction, especially if the meatus is closed for a moment so as to obtain the full dilating power of the water. Failing in this effort, if the foreign body can be located and the urethra closed, a large injection of sweet oil may be thrown

in, after a hot bath, and the largest possible bougie carried down to the body to stretch the membrane, while pressure from behind is made, either by the surgeon's finger or by the expulsive efforts of the patient's bladder.

Should lodgement be made in the fossa navicularis, the spoon of the ordinary pocket-case can often be hooked behind the object and assist in coaxing it forward. A hairpin, or wire doubled upon itself and slightly bent, or a blunt curette, makes also a valuable extractor. An excellent instrument also is the articulated scoop of Leroy d'Etiolles, which, being introduced past the foreign body, has a mechanism by which its tip is then bent at right angles to the shaft, and is capable of making strong but dangerous traction. The abruptly short-beaked sound which I always use for sounding the base of the bladder can sometimes also be "wormed" past the obstruction and effect its dislodgement. I show you here seven prostatic stones that I have thus extracted, aided by the force of the urine. Long urethral forceps are of great service, as they serve partially to protect the canal during extraction; but they do so far less effectually than does the straight tube before described, which should be placed in every evacuating set. Hunter's or Civiale's three-bladed forceps are occasionally used; but I always look with abhorrence upon dragging any object forcibly through the canal. A dangerous instrument is the urethral lithotrite of Reliquet, as *incision* is infinitely safer for all rough and large bodies.

When the substance lies posterior to the triangular ligament, gentle attempts should be made to push it into the bladder, only after the evacuator has failed to dislodge it. If necessary to operate, the raphe should be closely followed, while a large staff is held in position to indicate the location of the obstruction and of the tube.

An incision in front of the scrotum is easily made, and should be closed after the removal of the body by catgut or quilled sutures. Treated antiseptically, and with either a retained catheter, or with frequent catheterizations, immediate union may be confidently expected. The quilled suture gives more perfect rest by its splint action.

If a stricture exists, and the foreign body is lodged behind it, dilatation or free external incision of the stricture should be practiced.

In former days, the instruments for search and removal of these objects, greatly exceeded those of the present day, when operative procedures are more common. The

"duplicators" of Mercier, and of Charrière, were intended to fold up any soft substance, as a very flexible bougie. Long stiff bodies were seized by "redressors" or "basculeurs," forceps with bevelled blades, constructed so as to rotate the body so that its long axis would correspond with that of the instrument. Occasionally a small lithotrite will answer for either of these purposes, but the great danger of laceration, during withdrawal through an unprotected canal, must never be lost sight of.

The curved forceps of Cusco or Voilemier are, perhaps, as useful in the bladder as in the membranous urethra; but I am afraid to use them for the reasons already named, especially since I have found suction so much safer and also more effectual.

For the removal of pins, bonnet pins, or needles, from the urethra, the point can sometimes be imbedded in a wax or gum bougie, but it is easier washed out with the evacuator. If immovable, the point can be pushed through the walls of the urethra, and by sharply bending the penis, the head after reversal drawn through the tube by suction or by forceps. It is seldom necessary to cut the pin when this method is used.

If a piece of nitrate of silver is lost from a porte-caustique, the evacuator, charged with salt water, should be at once used if the force of urination does not expel the mass.

Many ingenious devices have been practiced in the absence of instruments, to rid the urethra of impacted bodies, but the knife is far safer than rough instrumentation. In the absence of the straight evacuating tube,

an extra sized catheter, with open end, and a large syringe, might prove useful.

Blood-clots in the bladder are practically foreign bodies, and are best removed by gentle suction through the curved evacuator, or through the blood catheter, which I here show, the large eye of which is closed down during introduction by a spirally cut obturator.

Catheter accidents are so frequent that instruments should be often examined. Only recently I found that the distal extremity of my much-used pocket case instrument could be slipped from its screw-thread by a very small amount of traction. Old gum bougies should be thrown away as soon as they begin to lose their elasticity.

To summarize:

1. The litholapaxy evacuating tube, large, straight, and with open end, is the surest and safest instrument for the removal of foreign bodies from either urethra or bladder.
2. The fenestrated lithotrite should be employed to break up all bodies capable of division.
3. Incision of urethra or bladder is safer than a tear of the neck of the viscus or of the canal.
4. The suprapubic and median perineal are the safest routes of entrance to the bladder when suction fails.
5. Forceps should be used with the greatest care, and always through a straight tube, which insures protection both to the urethra and neck of the bladder during both exploration and extraction.

EDITORIAL DEPARTMENT.

PERISCOPE.

Therapeutics of Chronic Articular Rheumatism.

At the Sixtieth Congress of German Naturalists and Physicians at Wiesbaden, in September, 1887, Ziemssen read a paper on this subject, in which he made the following points: 1. Chronic articular rheumatism is a general disease: though at times it may be quite localized, yet there exists no surety that the disease may not again become general. 2. Therefore treatment must at the outset be general. 3. The disease is often so inveterate at special points that a combined local and general treatment is necessary. 4. In the affected joints are almost always found

separate spots with a distinct border, which can be accurately marked out by touch and by the sensation of pain on the part of the patient. 5. The pain is often complicated in such a way that either the diagnosis is doubtful, as in arthritis, syphilis, gonorrhoea and after injury; or that the pains belong to another kind of rheumatism, for example, muscular rheumatism, rheumatic neuralgia, sciatica and heart-disease. 6. Such complications are to be dealt with at the same time with the general disease. 7. Treatment is not to cease before complete cure is obtained, otherwise a relapse would not be surprising. The rheumatic diathesis itself is the uncured disease.

Treatment is general and local. General treatment consists in the regulation of nutri-

tion, in an out-door life, in promoting increased activity of the skin, in the use of warm and hot baths, in wearing woolen clothing, and a regulation of the whole style of living; and finally in large doses of salicylate of soda. This remedy is, when rightly used, very well borne, has no contra-indications, and acts so specifically that when failure results from its use an error in diagnosis is to be inferred. The local treatment, which is to be employed simultaneously with the general treatment, consists in the use of massage, combined with warm douches while the patient is in a warm bath. By means of tubing and a bellows, a stream of water, under a pressure of three to seven atmospheres, is projected against the affected part, which at the same time is manipulated by a skilled attendant. This treatment excels all other local measures. In other rheumatic affections, such as muscular rheumatism and sciatica, this method of treatment by douche is very efficient.—*Deutsche Medicinal-Zeitung*, November 3, 1887.

A Case of Suppurative Peritonitis.

George J. Robertson, surgeon to the Oldham Infirmary, reports a case of suppurative peritonitis to the *Medical Chronicle*, November, 1887, the history of which is briefly as follows: Fred. O., three years of age, on December 31, 1885, fell, striking his belly against a small boulder, which was fixed in the corner of a street. He returned home evidently in great pain. Following the injury he became dull and languid, gradually failed in health, and became fretful and disinclined to play. He complained of pain in the belly, the right side of which was tender on pressure. He also for some time walked as if slightly lame, and with the body inclined to the right. Nevertheless he was able to walk a mile to the doctor's house on April 29. An examination made at this visit developed pain in the cæcal region, with a feeling of ill defined resistance, but no dullness on percussion. Symptoms of suppurative peritonitis—abdominal pain and distension, nausea, fever and rapid wasting, semi-recumbent posture, with legs drawn up—became so pronounced that an abdominal section was deemed justifiable, and was performed on May 14. The abdominal cavity below the umbilicus was found to be converted into an abscess sac, the upper limit of which was formed by coils of intestine glued together by recently effused lymph. No perforation seems to have been discovered in the region of the cæcum.

The cavity of the abdomen was thoroughly washed out with several quarts of warm water, every care being taken not to disturb the cohesion between the coils of the bowel. Drainage was provided for by rubber tubes.

Within a few hours after the operation, the general condition of the patient had improved, and convalescence continued so satisfactorily that, by June 3, the last piece of drainage tube was removed, and, by July 17, the abdominal wound had entirely healed.

The Connection between Syphilis and Tabes Dorsalis.

H. Nägeli, in a dissertation published at Zürich, in 1887, discusses forty-six cases of tabes dorsalis lately observed in the polyclinic and in the private practice of Professor Bernhardt, at Berlin, and expresses the opinion that of the forty-six cases twenty-eight, that is to say sixty per cent., had syphilis. He then gives a summary of all the existing literature bearing upon the relation between tabes and syphilis. Of the 1403 cases collected, syphilis had certainly preceded in 46 per cent., while 14.5 per cent. were suspected of syphilis. On the whole, therefore, the number who certainly had syphilis, plus the number suspected, comprised 60 per cent. of all the cases. On the other hand, an examination of 1450 persons who were non-tabetic showed the presence of syphilis in only 22 per cent. of the patients.—*Centralblatt f. d. med. Wissensch.*, Sept. 10, 1887.

Cocaine in Diseases of the Stomach.

At the meeting of the French Society for the Advancement of Science, at Toulouse, in September, 1887, M. Salet stated that he had arrived at the following conclusions:

1. Cocaine acts upon the mucous membrane of the stomach and intestine just as strongly as it does upon external mucous membranes.
2. In order that the action may be complete, remove the gastric and intestinal secretions, and combine cocaine with alkalies.
3. To this mixture may be added some morphia, in order to make the duration of the action as long as possible.—*Deutsche Medicinal-Zeitung*.

—The news from Europe indicates that there can be no doubt that the Crown Prince of Germany has an epithelioma of the larynx, and that it is progressing rapidly.

A Case of Profuse Galactorrhœa.

Dr. S. Gottschalk, of Berlin, reports the following case in the *Deutsche Medizinische Zeitung*, October 10, 1887:

Marie Mitschriek, a girl twenty-two years old, who never had been seriously sick, began menstruating at the age of sixteen. Menstruation was regular, but scanty. On January 23, 1887, she was delivered of a child at seven months, which died eight days after birth. Following confinement, menstruation was not resumed; but a galactorrhœa set in, which was so profuse as to make it impossible for her to keep the neighborhood of the mammæ dry, although she changed the linen three or four times a day. If the breasts were not compressed by bandages, the milk escaped in jets. As a result of the constant wetting of the skin, a severe eczema developed over the whole anterior surface of the thorax. As the health of the patient steadily declined, while the eczema rapidly increased, treatment was sought for the skin affection; but the cause of the trouble being recognized, she was referred to Dr. Gottschalk. The latter found, on July 22, that the woman was very cachectic, and that both mammæ and the surrounding surfaces, as far down as the liver and stomach, were covered with a very pronounced eczema. The mammary glands themselves were flabby, and from the nipples there was constantly discharged a fluid resembling milk and water. On the whole, the patient presented a phthisical aspect (her father was phthisical), but no objective signs of lung disease were demonstrable.

An examination of the uterus disclosed atrophy of the organ with a mucous discharge from the external os. The vagina at its entrance was eroded, while both vagina and uterus were very flabby. Thinking that this condition of affairs explained both the amenorrhœa and galactorrhœa, the author simply anointed the breasts with vaseline, and applied cotton over it to keep the tissues dry; and then directed treatment to the uterus. The latter was repeatedly scarified, superficially, twice a week. For the erosion, the patient used at home vaginal irrigations of lukewarm water, with the addition of pyrolignous acid. Internally, the patient was given the solution of the albuminate of iron.

The secretion from the mammary gland steadily diminished from the beginning of the scarifications, and ceased after the treatment had been continued three and a half weeks. The eczema vanished with the galactorrhœa, simply under the use of vaseline;

the cavity of the uterus showed the normal dimensions on being tested with the sound; the tissues around the uterus have a much firmer consistency; and, though menstruation has not yet been freely established, the general condition of the patient is quite favorable, and her weight has increased.

Avulsion of Ingrowing Nail Under Hypnotism.

Dr. S. L. Trivus, of St. Petersburg, relates (*Vratch*, No. 31, 1887, p. 607) a case in which he removed an ingrowing nail from the great toe of a cook after a hypnotic state had been induced in the patient. The operation lasted about twenty minutes. At first the woman occasionally moved her foot about, but when the author had suggested to her that no more pain was to be inflicted, and that the foot must be kept at rest, she sat quiet till the matrix of the toe was incised. At that point of the operation she shrieked out, and, when questioned about the cause, stated that "a dog had just bitten her." After applying the dressing, Dr. Trivus woke her up, and asked whether she would consent to the operation. She hesitated a little, and then said, "Yes, go on." On his pointing to her bandaged foot, however, she at once guessed that all was over already, and burst into laughter followed by hysterical sobs. No pain was felt till the next day, when she became somewhat lame. Dr. Trivus also relates an instructive case in which a young man of 25, after having been hypnotized for the sake of experiment, and subsequently awakened, could not return to his normal state for several hours; when left alone, he was seized with a kind of hypnosis, and on his way home fell into a deep swoon in the street.—*Brit. Med. Journ.*, Oct. 15, 1887.

Treatment of Erysipelas.

In a recent work on the antiseptic treatment of wounds, von Nussbaum strongly recommends the treatment of erysipelas by smearing the inflamed area with the following ointment:

R. Ammonii sulphoichthiolicæ.....1 part.
Lanolin.....2 parts.
M.

—*Centralblatt für Chirurgie*, Oct. 22, 1887.

—There have been eight cases of yellow fever and four deaths in Tampa, Florida, for the week ending November 23; making altogether 380 cases and 71 deaths.

THE
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N. A. RANDOLPH, M. D., } EDITORS.
CHARLES W. DULLES, M. D., }

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THE PHYSICAL DEVELOPMENT OF AMERICANS.

For a long time it was generally believed that the physical development of Americans was inferior to that of Europeans, and certain prophets of evil maintained that the average standard was becoming lower. The first of these beliefs may have been correct some decades since; but we think it is not correct now. A comparison of people in similar circumstances of life shows, we think, that the inhabitants of the United States are physically the equals of those of any country in Europe. One who has studied crowds, or bodies of soldiers, on both sides of the Atlantic, must feel that America produces men and women who are in no sense inferior to men and women anywhere. As to the idea that the physical development of our countrymen is deteriorating, it is interesting to note the result of personal observation and systematic study of this matter. We think that any one, who has had the question of the physical development of Americans in mind

for some time, will testify that personal observation leads to the conviction that the average duration of life, degree of health, and size of the bodily frame is increasing in America. The children are better developed, healthier and handsomer than they were twenty or thirty years ago; men are young men in spirit and in capability at forty and even fifty years of age now-a-days; old men and women retain their faculties longer than they used to do. In Philadelphia, the statistics of the *Public Ledger* leave no room for doubt on this subject.

As to the matter of bodily size, an interesting article from *Science*, Nov. , 1887, which we publish elsewhere, indicates that Americans are advancing, not deteriorating, in physical development. The investigations referred to show that in height and in girth the inhabitants of the United States are outstripping their predecessors, while in both they reach a standard which is very reassuring to those who may have been alarmed by the laments and solicitude of the ill-informed or timorous.

THE TREATMENT OF TYPHOID FEVER.

One of our subscribers has written to ask for an editorial upon the treatment of typhoid fever. This is a subject which might occupy much more space than falls within the limits of our editorial columns; but it may be possible within this space to offer a few suggestions which may be useful.

In the first place, we feel that most cases of typhoid fever require at the outset free cleansing out of the bowels. For this purpose a full dose of calomel or of blue mass, followed by some simple saline aperient, may be used. Afterwards, rest to the intestines may be secured by the use of a diet of milk, or broths, or of cocoa prepared with milk, in moderate quantities. The kidneys and skin may be kept active by the frequent administration of small quantities of sweet spirits of nitre in water. High temperature may be reduced very satisfactorily by the application of cold to the abdomen. A good plan is to lay a folded towel, which has been wrung

out of cool water, upon the abdomen, and to "iron" it with a piece of ice, when it gets warm. This method is often not only very efficient in reducing hyperpyrexia, but very agreeable to the patient, and we have some reason to believe that it acts beneficially upon the local inflammation of the intestines. If any drug be chosen for reduction of temperature, we think it should be antifebrine, giving fifteen grains at the start, and five grains every hour afterwards, until thirty grains in all have been taken, or the temperature has fallen two or three degrees Fahrenheit.

The systematic medication of typhoid fever patients should be confined within the narrowest limits possible. Often a dilute acid, like hydrochloric acid, will be all that is called for, and may be given in five or ten minim doses every four hours, in a dessertspoonful of elixir of calisaya, or a teaspoonful of tincture of lavender or cardamon.

For hemorrhage from the bowels, we know of no better remedy than gallic acid, in ten grain doses, given every hour until about a drachm has been taken. For syncope from hemorrhage, teaspoonful doses of whiskey in hot water are useful. For delirium, we know no good medicament, believing that it can only be benefitted by relieving the general condition which gives rise to it.

Our own experience has included a case in which there was hemorrhage from the bowels, from the kidneys, and from the lungs in the same patient. Although this patient, as might be supposed, came very near to death, and seemed for a few anxious hours to be beyond recovery, she ultimately got well. This case is mentioned to show that even a desperate case may recover with comparatively simple medication. It is true that cases treated simply may die; but experience and observation have led us to the conviction that in no disease is "incendiary medication" more dangerous than in typhoid fever; and, at the risk of unfavorable comment, we will add that we regard quinine, administered in large doses, as the most dangerous kind of medication in typhoid fever. Turpentine, which was so long considered almost specific

in typhoid fever, has lost its prestige; and cold baths we have never needed since adopting the plan of applying cold mentioned above.

In conclusion, we would commend to our readers the idea of simple medication, careful feeding, attention to the emunctories, and patience and courage. The latter qualities are often called for in the treatment of typhoid fever, and especially when grave conditions tempt one to institute methods of procedure or to administer drugs which, we fear, are sometimes the cause of the very issue they are intended to avert.

THE INFLUENCE OF TYPHOID FEVER UPON INSANITY.

"It is an ill wind that blows no one good." The appearance of typhoid fever among the patients at the State Hospital for the Insane, at Norristown, Pa., has given rise to a great deal of anxiety; but it has had a most fortunate and curious result in curing some of the patients, who contracted the fever, of their insanity. One woman, about fifty years old, who had suffered with chronic melancholia for several years, has been discharged perfectly well. Another patient, about twenty years of age, who had been in the hospital eight months with a second attack of acute mania, though subsiding somewhat at the time of the invasion, has gone home perfectly well. Another patient, a girl about eighteen years old, was beginning to recover from acute mania, when she sickened with typhoid fever. After the fever left her she seemed quite bright, although she is now inclined to be very dull and stupid. At any rate, a decided change has been produced in the mental condition of this patient.

It is well known that the bodily conditions are frequently altered after typhoid fever; the lean may grow corpulent, and those who were previously fat may grow lean. But it is not so generally known that disturbances of the cerebral functions are favorably affected, or that even the moral principles of an individual may undergo a

decided change. After this fever some persons have been known to develop a propensity for stealing. Dr. Crothers reports the case of a student of theology who, on recovering from typhoid, "betook himself to such a life as compelled him to pass most of his time in jail."

Dr. W. F. Waugh reported similar cases to the Pennsylvania State Medical Society in 1886. One young man, after being ill with typhoid fever for thirteen weeks, exhibited the delusion of grandeur and developed most unnatural tastes, acting consistently the part of the wealthy youth who is sowing his wild oats. A more gratifying phase of this mental revolution was the development of a talent for the work of a solicitor, which he never exhibited before his illness.

These curious results indicate the profound influence which such a disease as typhoid fever may exert upon the human economy, and discover it in an unexpected rôle of beneficence. In such cases as we have referred to it has proved a blessing, although a blessing very well disguised.

A HOSPITAL QUARREL.

Recent numbers of the *British Medical Journal* report a very unfortunate state of affairs in the Mercer's Hospital, Dublin. It appears that grave charges have been brought against Mr. O'Grady, senior surgeon to the hospital, by Dr. Knight, one of the physicians, including neglect of duty, abusive language to the governor, and uncivil treatment of the matron and of a fellow-surgeon. These charges were met by a general denial from Mr. O'Grady, and by counter-charges of animosity on the part of his accusers, and of offences which justified such proper reproofs as he had made in certain cases.

It is hard to judge of the merits of a controversy at a distance, and the evidence published in the *British Medical Journal* does not suffice to decide the merits of this one. But it clearly appears that the Mercer's Hospital is in a very unfortunate predicament, and that either the dissensions of its officers, or its bad management, or both, have dimin-

ished its field of usefulness very materially. This statement is made that the class of students has fallen from 190, in 1880, to 13, in 1887. Such a result cannot be an accident, and it seems high time that steps were taken to correct what is wrong.

These occurrences in Ireland have a practical bearing everywhere, as teaching the need for careful supervision of hospitals on the part of those who govern them, and for fidelity and courtesy on the part of their medical officers. We do not know of the occurrence of any such disgraceful dissensions in hospitals in this country; but neglect of duty and personal dislike are not unknown here, and it may not be amiss to call attention to what they have led to elsewhere, in order to strengthen the determination to subordinate personal feeling to the general good, which we believe prevails in American hospitals, and generally, we trust, even in those of afflicted Ireland.

RABIES FROM TANACETIC ACID.

At the meeting of the Academy of Medicine of Paris, October 18, 1887, M. Hayem read a paper by M. PEYRAUD, on "A Comparative Study of Tanacetin Rabies and True Rabies," (*Concours Médical*, Oct. 22, 1887). In this paper the author contended that the essence of tansy has a more powerful influence in producing rabies in all animals, except frogs, than true rabies has. The symptoms during life and the lesions found post-mortem are similar. The phenomena are due to excitation of the medulla oblongata, and of the roots of the pneumogastric nerves. (*Progrès Médical*, Oct. 22, 1887.) M. Colin, who knows a great deal about rabies, questioned the propriety of giving the name of rabies to the symptoms produced by tansy. In this he was, no doubt, right; but, as the diagnosis of rabies rests upon certain symptoms, which are held to be characteristic when they are seen in the subjects of other experiments, it is hard to see how their significance can be denied by some members of the French Academy in those of M. Peyraud.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the *REPORTER*.]

A TEXT-BOOK OF HUMAN PHYSIOLOGY.

By DR. L. LANDOIS, Professor of Physiology and Director of the Physiological Institute, University of Greifswald. Second American edition, translated from the fifth German edition. With additions by William Sterling, M.D., Sc. D., Brackenbury Professor of Physiology and Histology in Owen's College and Victoria University, Manchester, etc. One volume, royal 8vo, pp. viii, 451. Philadelphia: P. Blakiston, Son & Co., 1886. Price, cloth, \$6.50; leather, \$7.50.

This magnificent volume contains one of the best treatises on human physiology in the English language. It is the fruit of the patient and thorough work of a most competent German physiologist, done into good English by a worthy translator, who has added to it the result of his own extensive studies. We can recommend it to our readers in the most unqualified terms; and believe that it ought to have a place in the book-case of every studious physician.

TEXT-BOOK OF THERAPEUTICS AND MATERIA MEDICA. By ROBERT T. EDES, A.B., M.D., Professor of Materia Medica, and Jackson Professor of Clinical Medicine in Harvard University, etc. Large 8vo, pp. xi, 552. Philadelphia: Lea Brothers & Co., 1887. Price, in cloth, \$3.50; in leather, \$4.50.

In his paper, the author of this book states that he aims to present a concise, practical, working view of the present state of pharmacology and therapeutics, which shall select for the over-burdened student and young practitioner the more important and immediately applicable of the details which properly find a place in the larger and encyclopædic treatises. In this, we think, he has succeeded very well, and that his work will find a useful place in the field of instruction in the study of medicines and their uses. The personal opinions of the author appear, as he says, throughout the book, and they seem to reach a happy mean between too great credulity and skepticism. In the main, we think they will meet general approval. We have noted in this book some points which we think might be improved. One of these is the arrangement of headings in Section iii. Again, we have gone carefully through Section iv, headed "Prescriptions and Incompatibles," to find what we regard as a very inadequate description of the former, and no mention whatever of the latter.

In regard to the application of drugs, we find, for example, that while the dose of iodoform for internal use is given, there is an utterly inadequate statement as to the conditions in which it may be used. In the same connection, we note that its external use is described as part of a system of dressing wounds "consisting essentially in a careful washing with carbolic acid" (!). Of course the author does not intend exactly what he says; but exactness is no mean virtue in books on therapeutics.

These criticisms, however, must not be taken to indicate that we fail to appreciate the excellences of this book; on the contrary, we think it one of much value and to be recommended to our readers. Those of them who have no work of this kind published within a year, will find much in it which will be new to them, and more that will be useful.

DIET, IN RELATION TO AGE AND ACTIVITY. By SIR HENRY THOMPSON, F.R.C.S., Surgeon Extraordinary to his Majesty, the King of the Belgians, etc. From the tenth English edition. Small 8vo, pp. vi, 94. Boston: Cupples & Hurd, 1888. Price, 50 cents.

On turning the title page of this interesting and valuable little book, we meet the gratifying statement that it is "published by arrangement with the author." This is the best thing which a high-minded publisher can do under the existing conditions of international law in regard to copyright, and we congratulate author and publishers upon it.

The contents of Sir Henry Thompson's book are such that it is no wonder it has already passed through ten editions in England. It is full of wise suggestions, couched in very pleasing style. Sir Henry is no vegetarian, and speaks with ill-concealed scorn of those who assume this title: principally because it is not an accurate one. He finds fault with so-called vegetarians for eating eggs and cheese, and drinking milk. In this, we think he is a little captious. As he admits, it is hard to find a name which conveniently and accurately describes those who are vegetarians only in the sense that they do not eat flesh; and this is the essence of what is called vegetarianism—to find too much fault with the term is hypercritical. With the principle of avoiding flesh as an article, Sir Henry himself seems to agree, when discussing the diet of children, in whom, as he says (in another connection) the processes of growth and development go on most actively.

These comments will indicate, we believe, what may be expected by those who read this little book, for which we heartily wish a wide circulation.

CHILD'S HEALTH-PRIMER FOR PRIMARY CLASSES, PATH-FINDER PHYSIOLOGY NO. 1. 5¼x7½ inches, pp. viii, 124. New York and Chicago: A. S. Barnes & Co. Price, 35 cents.

This book is one of a series intended for use in schools. Its purpose is to instruct children in certain elementary principles of anatomy and physiology, with the special object of dissuading them from the use of alcoholic liquors, tobacco and opium. We have such a hearty sympathy with this object, that we are disposed to be lenient with what we believe to be the extravagance of many who have it very much at heart. In the book before us, we find—with much that is excellent—some statements in regard to both alcohol and tobacco, which are not so commendable from the scientific as from the moral standpoint. Fermentation, for example, may be "spilling" for the cook; but it is not so for the chemist; and if we regard what undergoes retrograde metamorphosis as thereby made unfit for rational use, what will become of sauerkraut and Roquefort cheese? Again, coffee and tea are as truly poisons as is alcohol, and by some are held to do a great deal of harm in the world, although no one can pretend that their injurious effects can be fairly compared with those of strong drink.

So much for the manner in which the book before us deals with its subject. For the object of the book we have much sympathy, and think, even with the qualification we have expressed, that it is calculated to do much good. Its style is simple and attractive; its teachings are on the whole sound; and it is illustrated in a way which will prove pleasing to those for whom it is intended.

VISITING LISTS FOR 1888.

1. THE PHYSICIANS' VISITING LIST. Twenty-seventh year of publication. From P. Blakiston, Son & Co., Philadelphia. Price, for 25 patients a week, \$1.00; for 50 patients per week, \$1.25.
2. THE MEDICAL NEWS VISITING LIST. 1888. From Lea Brothers & Co., Philadelphia. Price, for 30 patients a week, \$1.25.
3. THE PHYSICIANS' PERFECT CALL-BOOK AND RECORD, from 18. to 18. From George S. Davis, Detroit. Price, for 32 patients per week, \$1.50.

These are all good books; the first has been so long before the profession that it needs little recommendation; the second is in the third year of publication, and is one of the handsomest books we have seen; the third is a new-comer, very handsomely prepared and conveniently arranged. They have our best wishes, although we naturally think the readers of the *REPORTER* would do well to stand by the "Pocket-Record" published at this office, which will be issued, *thoroughly revised*, and with new features introduced, in December.

LITERARY NOTES AND QUERIES.

[In this column the *REPORTER* will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—The first number of *Woman's Work*, published at Atlanta, Ga., is sent to us, with an appeal for notice. The paper contains a good deal of useful and interesting reading, interspersed with most unblushing quack advertisements. One doctor, who advertises a panacea for the pains and dangers of childbirth, has four advertisements, and cures for catarrh and the opium habit come in for their full share. The whole paper presents a curious mixture of religion, quackery and popular science, which will hardly recommend it to medical men.

—*Lippincott's Monthly Magazine* announces that the experiment of introducing a complete novel into each number, and otherwise popularizing its contents, has proved a phenomenal success, and that neither pains nor expense will be spared to continue this success in the future. The prospectus for the year 1888 is very attractive, and promises to add materially to the interest and value of this excellent magazine.

—The *Nation* brings each week a store of timely comments on political affairs in the United States, a summary of the most important events of the week at home and abroad, and valuable criticisms on current or recent literature. The *Nation* occupies an almost unique position in literary and political matters, which has been secured by earnest efforts to advance the cause of good literature and good government.

—The first number of the *Medical Waif*, "a practical, monthly medical journal, devoted to diseases of children, women, rectum and anus," lies before us. It is published at La Fayette, Ind.; subscription price, \$1.00 a year. It contains so many evidences of ignorance or carelessness, or both, that it puts a severe strain upon the kindly feelings we entertain toward all of our contemporaries, and the disposition we have to give a cordial welcome to any new-comer which seems to have in it the promise of usefulness.

CORRESPONDENCE.

The Conjugal Question.

EDS. MED. AND SURG. REPORTER:

Sirs:—Having noticed some little discussion upon "The Conjugal Question" in the columns of the *REPORTER* of late, I venture to make a few comments upon the subject in its relation to health and disease. In several instances I have clearly traced the cause of a broken constitution and poor health to excessive sexual indulgence. Such a cause is generally denied by both parties when questioned directly upon the matter; and when cornered they will reply that they did not know that such indulgence was excessive. I have known of parties who indulged in the sexual act every night, excepting when menstruation was in progress, and to keep it up for long periods of time. The wife was not the only one to suffer, but in many instances the husband also, while in some cases the wife apparently was undisturbed, while the husband would be the one to complain. These are not fancies, but facts. Only a year or two ago, in a town not far distant from here, there were several reported cures among women who had been afflicted with poor health, the party treating them being a traveling quack, who in each instance said that the husband must sleep in a separate bed during treatment. I do not pretend to say that either party was brutal or more to blame than the other, but that such a state of affairs is more prevalent and responsible for more injury than the profession generally apprehends, calling for a consideration of it as a factor in the treatment of certain classes of disease. I have also seen weakly persons of both sexes benefitted by marriage, and it is only when certain physiological laws are perverted that it ceases to be a virtue.

M. F. STULTS, M.D.

Wiota, Iowa, Nov. 18, 1887.

Painful Tumor Near the Cæcum.

EDS. MED. AND SURG. REPORTER:

Sirs:—There is a disease near the cæcum which I have never seen mentioned in any of our books, and the only account of it, of which I have any knowledge, is by Dr. James Jackson, of Boston, some forty years ago. During the last thirty years, I have met with this condition thirteen times.

It may be known by a sense of uneasiness in the iliac region, which gradually increases to pain; and if neglected, it will resemble the symptoms of partial enteritis. The bowels

are always constipated. The part is tender, and upon pressure, a tumor, somewhat larger, but flatter, than an almond, may be detected, and it is somewhat moveable. It can be found on a line drawn from the ant. sup. spinous process of one ilium to that of the other, at the outer edge of the rectus muscle; and in order to find it the fingers must be pressed down to some little depth. The tumor never subsides suddenly to justify the suspicion of pus or fæces. The tumor feels something like an enlarged lymphatic gland. These cases are very liable to relapse unless the habits, food and drink are controlled with a good deal of strictness.

The treatment is pretty much the same as for enteritis, with some exceptions, however. In severe cases, leeches; in others, opiates, with calomel. After the pain has considerably subsided, the use of purgatives seems to improve the disease greatly. In the course of a few days, a two-inch blister, which may be repeated. In old or severe cases, the tumor may remain for a time, with some tenderness, after recovery, in all other respects, has taken place; in this state the external use of iodine, kept up for a long time, may be useful.

BACKWOODS.

London, Ont., Nov. 15, 1887.

NOTES AND COMMENTS.

Herpes Zoster Ophthalmicus.

Dr. Kent K. Wheelock, Professor of Diseases of the Eye and Ear in the Fort Wayne College of Medicine, in a paper read before the Allen County Medical Society, reports the following interesting case:

A. F. K., a German, aged 55 years, and a farmer by occupation, applied for treatment on March 19 of the present year. He is a strongly built man, and seems possessed of great physical strength. When the patient was first seen, he gave evidence of great physical suffering; the cheek and nose on the right side were swollen and glazed; the right side of the nose very red and studded with an eruption, which was circular in shape and covered with crusts having the appearance of being composed of lymph, serum and red blood corpuscles. The supra-orbital region on the right side was red, swollen and glazed, and the region over the course of the supra-orbital nerve very tender to the touch; the region of the supra-trochlear nerve was tender upon pressure; the redness, swelling and pain were confined to the right side of the median line of the head

and face; the conjunctiva and sub-conjunctiva of the globe were very red, and a deep-rosy zone surrounded the cornea; a well marked plastic iritis bound the pupil to the anterior capsule of the lens, and a plastic exudate filled the pupillary space, leaving a clear spot about the size of a pin head; the anterior chamber was filled about one-fourth full of pus, and a neuro-paralytic ulcer of the shape of an irregular parallelogram covered about one-half of the area of the cornea. The cornea was perfectly anæsthetic, so that a tightly twisted spool of cotton could be rubbed over its surface without being felt in the least by the patient. Vision in the upper field was reduced to counting fingers at six inches. If this patient was suffering from either iritis or zoster ophthalmicus the case would have been regarded as a grave one, and the chances of saving the eye were further reduced by reason of the complication of plastic iritis. The patient had suffered excruciating pain, at first almost constantly, but latterly it was paroxysmal. The treatment was local and constitutional. To control the pain, hot applications were made and kept up uninterruptedly for some hours. A cantharides plaster about the size of a silver dollar was put over the distribution of the supra-orbital nerve. To cleanse the eye, a solution of bichloride of mercury warmed (1-4000) was employed every hour; quinine was pushed till its physiological effects were observed, and bromide of zinc and nux vomica were given for their sedative and stimulant action. No new eruption appeared afterwards, but at intervals paroxysms of pain, lasting several hours, came on. To control these, morphia was employed. In about one week the painful attacks became fewer and fewer, finally disappearing. The patient then complained that his eye-ball felt cold, like ice, and that he felt very much depressed and could not keep warm; that hot water did not restore warmth to the eye-ball. The Faradic current was then used to the extent of easy toleration. Immediately the cold sensation passed away, and returned again once or twice, and then only for a short time. After a few applications of electricity sensation returned to the eye-ball, being observed at that part corresponding to the area of pus in the anterior chamber. Returning sensation and thinning and narrowing of the ulcer were about simultaneous. One peculiar effect of the electricity was observed at a certain visit. A small ulcer, the size of two pin-heads, occupied the centre of the cornea, shading off into a general haziness.

After using the current about twenty minutes, one pole applied to the eye-ball through the upper lid, the other to the base of the skull, another examination showed complete absence of ulcerated area, the depression having become filled up, and the cornea appeared bright and clear. The area of sensation at this visit was small before applying the current, but after use of the electricity there were several sensitive points. At this time the author was using electricity twice weekly, keeping up the strychnia.

At his last visit there was still some circumcorneal redness and areas of corneal insensibility. The pupil was then almost entirely occluded with plastic lymph, notwithstanding the free use of atropia.—*Fort Wayne Journal of Med. Science.*

Supplementary Mammary Glands.

Dr. D. C. Holton, of Brooklyn, sends to the *N. Y. Med. Journal*, Nov. 12, 1887, a short account of a case in which, on the third day after parturition, the patient complained of her breasts, for which he gave certain directions as to treatment. At his next visit he was told that the breasts were better, but that "the lumps under the arms" were still hard and painful, and that the patient had to lie with her arms over her head to prevent pressure on them. On examination, he found what at first appeared to be axillary lymphatic glands very much enlarged, but proved, on closer examination, to be supplementary mammary glands. They were situated one at the anterior border of each axilla, each being about as large as a duck's egg and having a small but distinct nipple with a faint areola surrounding it, and milk could be pressed from the nipples. It was the patient's third confinement, and she stated that the "lumps" had appeared with every child.

In the *Edinburgh Med. Journal*, November, 1887, Dr. Hartley Dixon reports the case of a woman having four breasts. About the fourth day after the completion of labor he had occasion to examine the breasts, and noticed a slight swelling below the right breast which was very soft on pressure. A fuller examination revealed the fact that the right and left mammae were fully developed; the nipple of both was very prominent; the areola dark and wide. About two inches below the lower border of the base of the right mamma, commenced the base of another distinct mamma, measuring at its base $2\frac{3}{4}$ inches; the nipple of this one also was distinct, and the areola dark. This became

filled with milk at the same time as the right mamma, and on slight pressure gave the uneven surface which is caused by the lobes and lobules of the normal mammae. On the left side, about the lower border of the tenth rib, was a distinct prominence, with a decided areola, but no nipple. This did not seem to have any connection with the left mamma. The mother stated to Dr. Dixon that her other three daughters had no marks of any kind upon them.

The American Physique.

Mr. Edward Atkinson has a letter in *Science*, November 11, 1887, in which he says: Last spring I received a letter from an English gentleman who is interested in anthropology and biology, asking me if there were any facts to sustain the impression abroad that the white man is deteriorating in size, weight, and condition in the United States. I had no positive information of my own to give, and I could only refer my correspondent to the data of the measurement of soldiers, and to some other investigations of less importance.

It occurred to me, however, that, since by far the greater part of the men of this country are clad in ready-made clothing, the experience of the clothiers might be valuable, and that, from their figures of the average sizes of the garments prepared by them for men's use, very clear deductions could be made as to the average size of the American man.

I therefore sent a letter to two clothiers in Boston who have been long in the business, one in Chicago, one in New York, one in Baltimore, one in Detroit, one in Texas, and one in Montreal. The information received in return is to this effect:

In any given thousand of garments the average of all the returns is as follows: chest-measure, 38 inches; waist, $33\frac{1}{2}$ inches; length of leg inside, $32\frac{1}{2}$ inches; average height ranging from 5 feet $8\frac{1}{2}$ inches to 5 feet 9 in New England, up to 5 feet 10 for the average at the South and West. A few deductions of weight are given from which one can infer that the average man weighs between 155 and 160 pounds.

My correspondent in Chicago states "that, so far as relates to the assertion that the race in this country deteriorates, our experience teaches us the contrary is the case. We are now, and have for several years past, been obliged to adopt a larger scale of sizes, and many more extra sizes in width as well as in

length, than were required ten years ago. Different sections vary very much in those requirements. For instance, an experienced stock-clerk will pick out for South and South-western trade, coats and vests, breast-measure 35 to 40, pants always one or two sizes smaller around the belly than the length of leg inside; for Western and Northern trade, coats and vests, breast-measure, 37 to 42, pants 33 to 40 around the belly, 30 to 34 length of leg inside."

My correspondent in Texas gives the average 38 inches chest, 33 to 34 inches waist, 32½ leg-measure, 5 feet 10 inches height, adding, "We find that the waist measure has increased from an average of 32 to 33 inches during the past five years, and we think our people are becoming stouter built."

My correspondent in Baltimore had previously made the same statement: to wit, "Since the late war we have noticed that the average-sized suits for our Southern trade has increased fully one inch around the chest and waist, while there has been no apparent change in the length of pants."

I asked this firm if the change could be due to the fact that the colored people had become buyers of ready-made clothing, but have for reply that the fact that the negroes are buying more ready-made clothing now than previous to the war, accounts in only a small degree for the increase of the size, but is due almost entirely to the increased physical activity on the part of the whites. The experience of this firm covers thirty-five years.

My correspondent in New York states that "for the last thirty years our clothing, numbering at least 750,000 garments yearly, has been exclusively sold in the Southern States. We find the average man to measure 37 inches around the chest, 32 to 33 around the waist, 33 to 34 inches length of leg inside, average height 5 feet 10 inches. The Southerner measures more in the leg than around the waist,—a peculiarity in direct contrast to the Western man, who measures more around the waist than in the leg."

Possibly the average size for a woman could be deduced from the data of manufacturers of knit goods. From what I know of the business of the clothiers to whom I made application, I should infer that the figures which I have submitted above would cover more than one hundred million garments; and I know of no better method of coming at a rough-and-ready conclusion regarding the size of men, than the one which I have adopted.

Contusion of the Abdomen, with Rupture of the Intestine.

In an experimental and clinical paper on this subject in the *American Journal of the Medical Sciences*, October, 1887, Dr. Curtis sums up the practical results of his inquiry in three propositions:

"1. The treatment of contusion of the abdomen should be purely expectant in the early stage, until symptoms of internal injury have appeared, or until the full extent of time in which they may be expected has passed. Explorative laparotomy at this time is inadmissible.

2. When symptoms of uncontrollable internal hemorrhage or serious visceral injury appear, laparotomy is indicated; but, when the diagnosis is uncertain, the operation should always be begun as an exploration.

3. Great collapse is an absolute contraindication to all operative interference.

4. When rupture of the intestine is found, the best method of treatment is to secure the injured gut in the abdominal wound and form an artificial anus. This can be easily relieved by a later operation when the patient has recovered his strength."

Regurgitation of Milk Through the Ear.

Dr. H. F. Hendrix, of St. Louis, reports the following interesting case in the *St. Louis Medical and Surgical Journal*, November, 1887.

Eddie J., two weeks old, applied for treatment, because he could not nurse well. On inspecting the fauces, the soft palate was found to be absent, which accounted for the trouble in nursing. The child could not exhaust the air in the mouth sufficiently to cause the milk to flow readily; he therefore had to be fed by hand, and did not nourish well at any time. When he was three weeks old, his right ear began to discharge a thin, watery matter containing a slight amount of pus. This continued for a time, when it was noticed that in feeding, while lying on the right side, milk would flow from the corresponding ear, and some of it coagulated or curdled in the aural canal. Finally, at the age of eight months, he contracted whooping cough. The other ear now began to discharge as the right one had done, and soon the milk began to run from it when the child nursed while lying on the left side. At this time also measles supervened, and subsequently diarrhoea, which was too severe for his feeble constitution, and he died.

Measles followed by Gastric Ulcer and Fatal Hemorrhage.

In the *N. Y. Medical Journal*, October 29, 1887, Dr. Robert Abbe reports a case of measles occurring in a young woman twenty-two years of age, who had previously been in excellent health. At first the attack seemed to be of ordinary severity; but, at the end of a week, it was accompanied by much prostration, a disposition to syncope, rapid wasting, sallow skin, and a striking loss of tone in the skin, which, when pinched up, sluggishly returned to its place. Subsequently the eruption became hemorrhagic. Convalescence was slow, and a "purulent bronchitis" seemed for a time about to degenerate into phthisis. After an absence of two months in the South, she returned apparently in excellent health, but soon developed symptoms of gastric ulcer. One morning, after breakfast, she was seized with pain in the side and nausea, and rushed to the bath-room and vomited about three pints of blood, one pint of which was pure blood. Collapse followed the hemorrhage, from which she but slowly reacted. Twenty-four hours later, when about to receive a nutritive enema, she again vomited; this time altogether about a teacupful and a half. After this second hemorrhage she had three large, fluid, tarry stools. Six days afterwards she developed a parotid abscess, which was opened; the fever, nevertheless, kept up, and the patient died on the thirteenth day after the last hemorrhage.

The autopsy showed, in addition to marked anæmia of all the organs, a stomach which was normal in size and location: the cardiac and pyloric orifices were normal in size and perfectly free. The mucous membrane was smooth and very pale in color. In the posterior wall, six centimetres from the œsophageal orifice, and just to the right of a line drawn parallel to the œsophagus, was an apparent loss of the mucous surface, circular in shape and six millimetres in diameter. In its centre was a hard nipple-shaped elevation, and beside this elevation, extending transversely across the implicated area, was a vessel with thin walls partially filled with blood. There was no elevation of the edges of the area, and by the unaided eye it could not be identified as an ulcer. Microscopic examination of the area showed a total loss of the mucous membrane to the extent of the measurements given above. At the base of this ulcer were seen an artery and vein of considerable size. The walls of the vein were everywhere intact. The hard, nipple-like elevation already described was the rup-

tured wall of an artery. Sections carried along through the entire ulcer showed a rupture of the artery involving one-half of its wall. The other half showed no evidence of disease. A mass of fibrin and blood clung to the ruptured wall, and, for a short distance on either side of the rupture, the wall was split up and contained fibrin and blood. There was a zone of small round cells surrounding the ulcer, and at the bottom the capillaries were filled with blood, and the round cells of inflammation infiltrated the connective tissue. Sections made in other parts of the stomach revealed no lesions of its coats or vessels.

Most cases of "black measles," of which this was an example, are the result of a low grade of catarrhal pneumonia which occurs as a sequel to the attack of measles. It is possible that, in this case, what is described by the author as purulent bronchitis was, or was accompanied by, catarrhal pneumonia.

Champagne vs. Cholera.

In *Littell's Living Age*, Nov. 12, 1887, there is an interesting article, from the *Edinburgh Review*, on Dr. Guillemand's book, "The Cruise of the Marchesa," in which the statement is made that, at Macassar, champagne is supposed to be a good prophylactic against the cholera. At a ball, the foreign guest was urged by his Dutch hosts to drink freely in order to escape the dreadful scourge. "Float the liver, my dear sir; keep your liver floating constantly in champagne, and you will never catch the cholera," was the advice given.

Vicarious Menstruation.

A woman in the clinic of Dr. Buman, of Freiburg (Switzerland), was suffering from a carbuncle which had made its appearance in the lower abdomen. The necrosed tissue was removed about the time the patient should have menstruated. The menstruation did not appear in the usual manner, however, but in the shape of an abundant hemorrhage from the solution of continuity caused by the carbuncle. The hemorrhage lasted three days, and subsided without further phenomena.—*Med. Press* (N. Y.), Nov., 1887.

Lime-Juice Cordial.

The *Chemist and Druggist* gives the following formula for this cordial:

Glucose.....	f3ij
Syrup.....	f3j
Lime-juice.....	f3j
Water.....	f3xiv
Tincture of lemon peel, triple orange-flower water, of each enough to flavor.	

NEWS ITEMS.

—Dr. Charles B. Nancrede has been elected Surgeon to the Jefferson Medical College Hospital, to succeed Dr. Richard J. Levis, who recently resigned.

—Dr. V. P. Gibney has been appointed surgeon in chief of the Hospital for the Ruptured and Crippled in New York, in place of the late Dr. Knight.

—The Boston Board of Health has voted to designate all houses in which there are cases of scarlet fever, by the display of a signal, after the manner already pursued in some country districts.

—The *Brit. Med. Journal* says that on November 9th there were 2692 patients in the London Hospitals, including 2539 with scarlet fever, 125 with typhoid fever, and 28 with other diseases.

—The typhoid fever, which caused forty deaths in Cincinnati recently, seems to be abating. The deaths last week numbered only twenty-six, and the number of new cases is diminishing.

—At Exeter, England, a clergyman, who was reading the burial service over the body of a young girl, was so affected by the circumstances surrounding her death as to lay himself open to a false charge of drunkenness.

—The *N. Y. World* says: Many of the leading figures in Continental politics are suffering physical ills. The Czar of Russia is slowly recovering from the measles, Prince Bismarck has the rheumatism, Emperor William, of Germany, has just had a severe attack of old age, the Crown Prince has had an alarming return of his throat trouble, the King of Holland and the King of Bavaria may die at any moment, and the Sultan of Turkey is said to be laboring under severe nervous depression. It is a busy time for Court physicians in Europe.

—The *Lancet* thinks that not the least important part of Sir James Paget's address at Manchester, England, was that in which he spoke of the value of private practice as a sphere for observation of facts, histories and cases extending over long periods of time, and in which successive members and generations of a family of practitioners may take part.

—Governor Hill, on November 19, appointed Mrs. Charlotte S. Williams, of Buffalo, and Mrs. Caroline B. Stoddard, of Rochester, as two of the managers of the State Insane Asylum, at Buffalo, to fill vacan-

cies. There are a large number of female inmates in the institution, and this fact induced the Governor to appoint a majority of woman as managers. The appointments were urged by numerous organizations of ladies.

—The business committee for the coming meeting of the Medical Society of the State of New York, consists of Dr. F. A. Castle, of New York (Chairman), Dr. A. Walter Suiter, of Herkimer County, and Dr. J. W. Whitbeck, of Monroe County. The members and delegates who intend to read papers at the meeting are asked to notify some member of the committee or the president, Dr. Alfred L. Loomis, of New York, before the 20th of December.

—The *Chicago Tribune* states that the farming community near Potomac, Ill., is alarmed over the prevalence of milk sickness, which has assumed an epidemic form. Three persons died last week from the disease, and others are not expected to live. The disease first made its appearance in the family of a man named Doane, the members of which contracted the disease from drinking the milk of a cow afflicted with it. The afflicted locality joins Salt Fork Creek, which has gone dry, and the malady is believed to have been caused by the drouth.

—In his annual report to the Secretary of the Navy, Surgeon-General F. M. Gunnell states that the condition of the medical corps of the navy urgently calls for legislative action. There are, he says, now twelve vacancies in the rank of Assistant-Surgeon. The loss of members in the active list of the corps during the year amounted to nine officers, while only six Assistant Surgeons were appointed. The report shows that the daily average number of sick in the navy was 204.69, the admissions per thousand of mean strength 901.59, and the deaths per thousand 54.4.

—The late Lady Brassey, who became generally known through her book, called "The Voyage of the Sunbeam," was long in such frail health, that most women in her condition would have given up to complete invalidism. She nevertheless took a most prominent part in all social, charitable and literary matters; and in her short life of about fifty years accomplished more real work than most people could do if they lived to be a hundred years old. This was the result of indomitable energy and perseverance, which, as in her case, are not infrequently associated with great brain power and weak lungs.

—A New York wine merchant is given credit to having said: "They make wine nowadays without a particle of grape juice in it. We have just received from Portugal a proposition to supply us with a secret coloring matter. The proposition has it all figured out for us to show that with any amount of their stuff, costing \$13 in our money, we can turn 1650 gallons of white wine into claret. They send a sample with the offer. Just so much of it as could be taken upon the point of a knife-blade turned a glass of water in an instant into the loveliest claret-colored liquid you ever saw."—*National Druggist.*

—The annual meeting of the American Academy of Dental Science was held in Boston recently. The annual address was delivered by T. C. Stellwagon, M.D., D.D.S., of Philadelphia, on "The Inheritance of Mental and Physical Characteristics." These officers were elected: President, Dr. Cecil Wilson; Vice-President, Dr. F. N. Seabury; Recording Secretary, Dr. V. C. Pond; Corresponding Secretary, Dr. E. B. Hitchcock; Treasurer, Dr. E. H. Smith. Executive Committee—Dr. F. O. Loveland, Dr. W. B. Parker and Dr. C. H. Taft.

—The Paris correspondent of the *Medical Press and Circular* reports to that journal the case of a respectable servant, who was ravished by two foot-pads after they had filled her mouth with sand, so that she could make no outcry. At the trial the lawyer selected to defend the villains did so by using his utmost endeavors to prove that the woman was a common prostitute, and hence a very willing victim. Her ravishers were convicted, but the poor woman was so profoundly shocked by the accusations made by the lawyer, that she had to be taken to a hospital delirious, and it is feared may permanently lose her reason.

—While Parisians were enjoying the prospect of a supply of pure water at an expense representing barely the cost of a railway several hundred miles long, Dr. Fontaine-Atgier, of Fontainebleau, now comes forward to remind us that the water of the Lake Leman is so infested with eggs of the bothryocephalus that the natives get their water-supply at some expense from mountain springs, and carefully avoid drinking the lake water. The helminth, it seems, is harbored by a fish called "Ferra," and readily finds a home in human intestines. Good water, then, must be sought for elsewhere. Those medical men spoil everything!—*Chem. and Druggist*, Oct. 29.

HUMOR.

—A London druggist has hit the popular taste for good bargains. In his window he displays a card that reads: "Come in and get twelve emetics for one shilling.—*Texas Siftings.*"

—*Even Doctors do it Sometimes.*—A Maine physician says that one day he saw a big crane standing on a log that floated near the shore on the Kennebec river. The crane had captured a large bug, which he dropped into the stream, so that it floated down past him, and then grabbed it and again repeated the performance. He kept this up for nearly half an hour, and then a pickerel darted up from below after the bug. This was just what the bird had been waiting for, and the next moment the fish was down his throat, and he was winging his way slowly up stream.

—This conversation occurred at Nottingham:

Lady (with a slight lisp)—"If you please, I want a pennyworth of *doo*."

Chemist—"I beg pardon?"

Lady—"If you please, I want a pennyworth of *doo*."

Chemist (rather perplexed)—"May I ask for what purpose it is required?"

Lady—"I understand it is a good thing to give babies when constipated."

Chemist—"Perhaps you have mistaken the name, and require manna?"

Lady—"Oh, yes. I knew it was something that fell from heaven, and thought it must be *doo*."—*Chemist and Druggist.*

—The New York *Sun* tells a story of a woman who was carrying three leeches home in a street-car from an apothecary's for her sick husband, when one escaped from the box and fastened upon her wrist. Piercing shrieks from the lady called the attention of the passengers to the mishap. One man, unusually bold, went to the rescue and removed the creature, but on replacing it in the box it was found that the other two had also escaped. A general panic ensued, with screams and mounting of seats by the female passengers, each of whom imagined she was wearing one or both of the other two leeches. A semblance of peace was restored only when the missing creatures were found in the matting of the car. Their spirit was broken and their functional usefulness past restoration, but the sick man for whose swollen leg they were intended, on hearing the story, laughed till the swelling went down.—*Med. Herald.*

—*A Clergyman Foiled.*—A clerical-looking gentleman, in the hope of obtaining a contribution, entered the office of a Texas newspaper, and, finding the editor at his desk, said: "I am soliciting aid for a high-toned gentleman of refinement and intelligence who is in need of a little ready money, but is too proud to make known his sufferings." "Why!" exclaimed the editor, "I'm the only man in town that answers that description. What's the gentleman's name?" "I am not at liberty to disclose his name." "It must be me, parson. God bless you and prosper you in your good work," said the editor, wiping away a tear. The editor says that the look the parson gave him as he went out will haunt him to his grave.

—In the village of O——, in central New York, lives a sharp-tongued old bachelor whom I have known for twenty-five years as "Uncle John." Uncle John is something of a character about town, and not destitute of Yankee wit and shrewdness. He used to make and vend in an amateurish way a certain cough mixture, the merits of which he preached to his friends with great enthusiasm, warranting the remedy to cure any cold in twenty-four hours "or no pay." One of his old friends, whom we will call Ike, being afflicted with a severe coughing cold, Uncle John used his best efforts in argument, persuasion, and finally vehement and profane scolding, to get him to try the remedy. But Ike could not be induced to "chance it." Not long after this Uncle John caught a hard cold himself, which was accompanied by a most distressing cough that shook his poor old frame unmercifully. It did not, however, prevent his coming down-town and "settin'," as he called, in Ike's market. The cold hung on for a week or more, and the cough had grown no better. Finally, one day Ike resolved to brave Uncle John's sharp tongue, and tease him a little about his failure to rid himself of the cold, and the following dialogue ensued. You are to understand that Uncle John's replies were interrupted with violent coughing.

"John?"

"What yer want?"

"Got a bad cold, 'ain't ye?"

"Yes; got the wust ever had'n my life."

"Hangs on pretty bad, don't it?"

"Yes; beats all."

Hesitatingly, "Why don't you try some o' y'r cough med'cine you wanted to sell me?"

"I thought mebbe y' was fool 'nough ter ask that question: d'yer s'pose I want ter live forever?"—*Harper's Magazine.*

OBITUARY.

JAMES BENNETT, F.R.C.S.E.

James Bennett, tutor in clinical surgery to Edinburgh University, died on October 19, of consumption of the lungs, at the age of thirty-one years.

W. F. TEEVAN, F.R.C.S.

Mr. W. F. Teevan died on October 22, at Hawkhurst, England, of aortic insufficiency complicated with blindness and insanity. He was educated at University College, London, from which he was graduated in 1858. He subsequently devoted himself to surgery, and particularly to genito-urinary surgery.

DR. H. L. VOGELBACH.

Dr. H. L. Vogelbach, recently resident of Melrose, Florida, died at Green Cove Springs, November 17. He was a native of Philadelphia and a prominent physician. In 1861 he enlisted in the 27th Pennsylvania Volunteers, but, after being promoted to captain, resigned on account of ill-health. In 1878 he came to Florida and located at Melrose. He took an active interest in all public affairs, especially school matters.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Nov. 20, 1887, to Nov. 26, 1887:

Lieutenant-Colonel A. K. Smith, Surgeon, assigned to duty as Attending Surgeon in New York City.

Lieutenant-Colonel J. R. Smith, Surgeon, ordered for duty as Medical Director, Dep't of Dakota.

Major S. M. Horton, Surgeon, granted six months' leave of absence on surgeon's certificate of disability.

Capt. W. H. Arthur, Assistant Surgeon, granted two months' leave of absence, with permission to apply for two months' extension, to take effect on the arrival at Fort Niagara, N. Y., of Assistant Surgeon Paul R. Brown.

First Lieutenant J. R. Kean, Assistant Surgeon, granted two months' leave of absence, to take effect about Dec. 1. S. O. 269, A. G. O., Nov. 18, 1887.

Capt. Paul R. Brown, Assistant Surgeon, ordered to Fort Niagara, N. Y.

Capt. John O. Skinner, Assistant Surgeon, ordered to Fort Ontario, N. Y.

Capt. Charles Richard, Assistant Surgeon, ordered to post near Denver, Col.

Capt. E. C. Carter, Assistant Surgeon, ordered to Willet's Point, N. Y. S. O. 270, A. G. O., Nov. 19, 1887.

List of Changes in the Medical Corps of the U. S. Navy, during the week ending Nov. 26, 1887:

Passed Assistant Surgeon F. S. Nash, detached from duty at the Smithsonian Institute, and ordered to the Washington Navy Yard.